COMMONWEALTH OF KENTUCKY

Personnel Cabinet
Department for Employee Insurance

Administration Manual

This manual has been designed to assist in the proper administration of the Public Employee Health Insurance Program. It is intended for use by insurance coordinators, agency personnel and contracted insurance carriers. All sample letters are available on the Department for Employee Insurance's (DEI) Web site. Insurance coordinators may download the letters from the Web site and customize for the individual agency's use. If the insurance coordinator does not have access to the Web site, please contact the DEI's Member Services Branch.

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ELIGIBILITY AND ENROLLMENT

I Eligible Participants

NOTE: For purposes of this Administration Manual, the term "employee" includes full-time employees, retirees and/or beneficiaries, classified or certified school employees and COBRA participants.

NOTE: Employees, retirees or COBRA participants and/or their dependents may only be covered under **one** state-sponsored plan.

A. Full-time employees

Full-time employees of the following agencies who contribute to one of the state-sponsored retirement systems are eligible to participate:

State Agencies;
Boards of Education;
Health Departments; and
Quasi Agencies

B. Retirees

Retirees, **under age sixty-five (65),** who draw a monthly retirement check from any of the following retirement systems are eligible to participate:

Judicial Retirement Plan
Legislators Retirement Plan
Kentucky Community and Technical College System (KCTCS)
Kentucky Retirement Systems (KRS)

- County Employees Retirement System (CERS)
- Kentucky Employees Retirement System (KERS)
- State Police Retirement System (SPRS)

Kentucky Teachers' Retirement System (KTRS)

C. COBRA Qualified Beneficiaries

D. Dependents

Dependents, which meet the following dependent eligibility requirements, are eligible for participation under the employees plan.

A dependent is:

- A member's spouse under an existing legal marriage;

- A member's unmarried legal child(ren) to age twenty-four (24) (the age limit) who resides with the member in a parent-child relationship and who is dependent on the member for more than 50% of their support and maintenance. For purposes of determining eligibility for dependent coverage, the term "legal child(ren)" includes (1) natural children, (2) stepchildren by an existing legal marriage, (3) children legally placed for adoption with, or legally adopted by, the member, (4) foster children, and (5) grandchildren and/or children for whom legal guardianship has been awarded.

  Also a dependent child is a child for whom the member or their spouse has a legal obligation under a divorce decree; court order; or an administrative order to provide for the health care expenses of the child. Eligible dependent children are covered to the end of the month in which they turn twenty-four (24).

- Dependents may only be covered under one (1) state sponsored plan. Unless both employees agree in writing, the employee with custody shall have first option to cover the dependent children.

- Eligibility may continue past the age limit for unmarried children covered under the Plan who are totally disabled and unable to work to support themselves due to a mental or physical disability that started before the age limit and is medically certified by a physician and that were covered under the plan when the disability occurred. The carrier may require proof of such dependent's disability no more than once a year. A total disability is defined as the condition that results when any medically determinable physical or mental condition prevents a dependent from engaging in substantial gainful activity and can be expected to result in death or to be of continuous or indefinite duration. The carrier must approve total disability.

II Employer Contribution

A. State Agencies, Boards of Education and Health Departments

In order to be eligible to receive the employer contribution, employees must meet one of the following:

- Full-time employees are eligible for the employer contribution for the following month after the initial waiting period for new hire, if during the month, they use:

- any combination of workdays;
- paid leave; and/or
- Family Medical Leave.

Refer to Chapter 6 for additional information on FMLA leave.

- Employees that are unable to work and elect to use paid leave or FMLA leave to qualify for the employer contribution must use those days consecutively.

- Employees returning from leave without pay (LWOP) must work at least one day in the month to qualify for the employer contribution for the following month (refer to Chapter 6 for additional information on LWOP).

- Employees who have exhausted paid leave and FMLA leave shall not qualify for the employer contribution for health benefits unless they work at least one day in the previous month.

B. Quasi Governmental Agencies

Insurance coordinators for quasi-governmental agencies should refer to their administrative regulations or internal policies if a discrepancy exists.

C. Dual Employment

Employees who work full-time for two (2) participating employers, and meet the eligibility requirements for both employers, are eligible for the employer contribution from each employer. However, employees are **only** eligible for health insurance coverage under **one state-sponsored plan**. Therefore, dual employees may take health insurance through one employer and waive coverage through the other employer and deposit any available employer contribution into a Health Care Flexible Spending Account.

III Levels of Coverage

Single – Covers the employee only.

Parent Plus – Covers the employee and one or more eligible children.

Couple – Covers the employee and the employee's spouse.

Family – Covers the employee, spouse and one or more eligible children.

IV Cross-Reference

Cross-reference is a payment option available to two (2) legally married participating members in the Public Employee Health Insurance Program. ***A cross-reference payment option terminates when one of the participating employees terminate employment; however, the level of coverage (Family) will remain the same. The remaining eligible employee will pay for the cost of the Family plan.*** As the insurance

coordinator, you should explain this to any employee selecting the cross-reference payment option.

A. Family plan

Two eligible members of the Public Employee Health Insurance Program may enroll themselves and their eligible dependent children in a Family plan and elect to pay by cross-reference. This means that the employer contribution for each eligible member can be combined to pay for the Family plan.

B. Cross-Reference Requirements

To be eligible to select the cross-reference payment option, each of the following requirements must be met:

- the members must be legally married (husband and wife);
- the members must be eligible employees or retirees* of a group participating in the Public Employee Health Insurance Program;
- the members must elect the same coverage;
- the members must elect coverage in the same county; and
- the appropriate health insurance application must be completed, signed by **both** members and filed with their employers' insurance coordinators.

Failure to meet any one of the above requirements will mean you are not eligible for the cross-reference payment option. For instance, if an active employee and a retiree wish to choose the cross-reference payment option, and they live in an out-of-state county that borders Kentucky, they will not be eligible for the cross-reference payment option. The retiree would have to select their home county and the active employee would have to select the county in which they work; therefore not meeting all of the above requirements.

**Members of the Judicial and Legislators Retirement Plans are not eligible to choose the cross-reference payment option.*

C. When can the Cross-Reference Payment Option be Selected?

Employees may select the cross-reference payment option at the following times:

- during the Open Enrollment Period;
- at the time of hire with a participating group - the newly hired employee must elect coverage to match the existing employee/retiree's elections;
- at retirement – newly retired members of a participating retirement system can elect a cross-reference payment option, if applicable. The new retiree must elect coverage to match the existing employee/retiree's elections; or
- during some Qualifying Events such as:
  - marriage - one member can change elections to match the other member's elections
  - birth/adoption and placement for adoption - only if there is no change in coverage elections by either member and if the

Qualifying Event makes them eligible to select the cross-reference payment option for the first time.

NOTE: ***If a member's spouse's employer joins the Public Employee Health Insurance Program during the plan year, the member and their spouse WILL NOT be allowed to elect a cross-reference payment option because no Qualifying Event has occurred.***

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D. Ending the Cross-Reference Payment Option

Employees will not be eligible to continue to pay by cross-reference if any of the following events occur:

- termination of employment – If one of the members in a cross-reference payment option terminates employment, **the cross-reference payment option will terminate.** The employee terminating employment has not experienced a loss of coverage; therefore, a plan level change is not permitted. The terminating employee is no longer eligible to receive an employer contribution; therefore, **the remaining member will be responsible for the payment of the Family premium; or**
- new Retirement – Newly retired members of a participating retirement system can elect to stop their cross-reference payment option. The spouse of the new retiree will be enrolled in a coverage level that corresponds to the new retiree's elections;
- experiencing a Qualifying Event that allows members to drop their spouse; or
- experiencing a Qualifying Event that allows members to drop their only dependent child.

V Initial Enrollment

Coverage for new employees will begin on the first day of the second calendar month following the employee's hire date. For example, if employment begins anytime in August the employee is eligible for coverage October 1.

New employees must complete a new application to apply for coverage or waive their coverage within the first thirty (30) days of employment. Employees failing to apply for coverage or waive their coverage within thirty (30) days will not have coverage and will not be allowed to enroll until the next Open Enrollment Period, unless an appropriate Qualifying Event occurs. The Group Health Insurance System (GHI) counts exactly thirty (30) calendar days beginning with the day after the hire date or event date.

NOTE: Insurance coordinators of quasi-governmental agencies should refer to their administrative regulations or internal policies if they have a different probationary period for benefit eligibility. The employee must sign the health insurance application thirty (30) days prior to the effective date of coverage. Employees failing to apply for coverage or waive their coverage within thirty (30) days will not have coverage and will not be allowed to enroll until the next Open Enrollment Period unless an appropriate Qualifying Event occurs. For instance, if your agency has a six (6) month waiting period before the health

insurance is effective and the employee is hired on January 1, they must sign the application prior to May 31 in order to be effective July 1.

VI Waiving Coverage

A. Waivers will only be accepted:

- during the annual Open Enrollment period;
- from a new employee no later than thirty (30) days of hire date or thirty (30) days prior to the effective date (for some quasi governmental agencies); or
- with an appropriate Qualifying Event.

To waive coverage, employees must complete all applicable sections of the health insurance application.

Employees, who waive coverage because they have coverage under one of the following, will be allowed to enroll in an available health plan during a Special Enrollment Period, if they can provide written proof that the previous coverage terminated:

- another employer's group health benefit plan;
- Military insurance coverage (Tri-Care);
- Medicare or Medicaid;
- COBRA (other than for non-payment); or
- State Continuation

Active employees, age 65 or older, that want to be covered by Medicare only, may waive health insurance coverage during the Plan Year they reach age 65. (Refer to the TEFRA Letter Appendix A).

B. Failure to complete an application within thirty (30) days of the date of hire or thirty (30) days prior to the effective date (as specified by your agency)

Employees who do not submit a health insurance application within thirty (30) days of their date of hire will not have health insurance and will not be eligible to enroll until the next Open Enrollment Period or until they experience a Qualifying Event that would allow them to enroll.

C. Failure to complete the required application during Open Enrollment

Employees who must make a change for the next Plan Year and who fail to complete an application during the Open Enrollment Period will not have health insurance and will not be eligible to enroll until the next Open Enrollment Period or until they experience a Qualifying Event that would allow them to enroll.

VII County Selection

Upon enrollment, members of the Public Employee Health Insurance Program have the following county selection options:

A. Active Employees Living and Working in Kentucky

Employees living and working in Kentucky may select coverage from their home county, work county or, if applicable, a contiguous county.

B. Active Employees Working in Kentucky and Living Out-of-state

Employees living outside of Kentucky, but working in Kentucky must choose a carrier that is available in the Kentucky county where they work.

C. Retirees Living in Kentucky

Retirees living in Kentucky must choose a carrier that is available in the county where they live.

D. Retirees Living Out-of-State

Retirees that live out-of-state but in a county that borders Kentucky must select coverage from the Kentucky county that the adjacent county borders. Retirees that live out-of-state beyond the border counties must select coverage from the following:

- Kentucky Retirement Systems retirees must select the coverage available in the home office county from which they retired (ie, a retiree working for the Transportation Cabinet in Pike County would select coverage from Franklin County because the Transportation Cabinet's home office is located in Franklin County).

- Kentucky Teachers Retirement System retirees must select coverage from the county in which they were last employed (i.e., a retiree that worked in Fulton County Public Schools would select coverage from Fulton County).

E. Contiguous County

Some employees may select coverage from a contiguous county. KRS 18A.225 (17) states that "if a state employee's residence and place of employment are each located in counties in which the hospitals do not offer surgical services, intensive care services, obstetrical services, level II neonatal services, diagnostic cardiac catheterization services, and magnetic resonance imaging services, the employee may select a plan available in a county contiguous to the county of residence that does provide those services, and the state contribution for the plan shall be the amount available in the county where the plan selected is located."

There are several hospitals in Kentucky that do not offer each of the services outlined above. However, based on the *regional* selection for coverage, only employees living in the following counties that meet the specifications outlined in KRS 18A.225 (17) would be eligible to select coverage in a contiguous county.

IMPORTANT: The GHI system can only keep one address on each member's record; therefore, the address that employees

provide on their health insurance application will be the only address used for mailing purposes and to determine your county of residence.

County	Region
Caldwell	Region 1 or 2
Casey	Region 4 or 5
Crittenden	Region 1 or 2
Hart	Region 3 or 4
Laurel	Region 4 or 8
Lincoln	Region 4 or 5
Marion	Region 3 or 5
Rockcastle	Region 4 or 5
Washington	Region 3 or 5

VIII Open Enrollment

Open Enrollment is a period of time for employees to make plan elections for the upcoming Plan Year. After Open Enrollment elections have been made, employees may only change their elections under very specific circumstances, such as experiencing a Qualifying Event, like marriage or birth. However, the election change must be consistent with the Qualifying Event.

IX Coverage Changes

If there is a change in family status as defined in the federal regulations, an employee must submit the appropriate documentation according to the Qualifying Event Chart in Chapter 3. If the appropriate paperwork is not signed by the employee within the specified timelines, the request for change will be denied.

X Transition from Dependent to New Employee

Dependent children that are already covered as dependents in the Public Employee Health Insurance Program and become employed by a participating employer, have the following options upon hire:

A. Become a Plan Holder

The dependent children:

- must complete a health insurance application as a new hire; and
- will be dropped from the parents' plan on the day prior to the effective date of their coverage as a plan holder.

NOTE: The plan holder does not need to complete a Drop Form to drop the dependent.

B. Remain as Dependents on their Parents' Plan

If, upon hire, covered dependents still meet the dependent eligibility requirements, the affected parties must do the following:

- the newly hired dependent children must complete a health insurance application to waive coverage; and
- the newly hired dependent children must also submit a notarized letter from their parent(s), as explained below.

    - The parents, under whom the employee is still covered as a dependent child, must provide the DEI with a written request to keep the child enrolled in their plan. The request must be notarized and it must state that the children still meet all dependent eligibility requirements of the plan after their employment. If the required documentation is not received by the DEI with the dependent children's application to waive coverage, the DEI will automatically terminate the children's coverage as dependents and will enroll them in their own plan (waiver or coverage).

NOTE: If the child being dropped is the only dependent child in the plan, the DEI will automatically assign the parent's coverage as follows:

- a Parent Plus plan will be assigned to a Single plan; or
- a Family plan will be assigned to a Couple plan.

In addition, neither the couple cross-reference payment option, nor the Single Commonwealth Essential plan is available for Plan Year 2005. Therefore, the following guidelines will be applied:

- a family Cross-Reference payment option will become two Single plans.
- Commonwealth Essential plans will become Commonwealth Enhanced Plans

The DEI will notify the parent's insurance coordinator of this action.

XI Transfers and Rehires

A. With break in service sixty-three (63) days or less

Employees who transfer or resign from any agency or organization within the Public Employee Health Insurance Program and do not experience a break in service of sixty-three days or less, must be reinstated to their prior elections, unless they experience a Qualifying Event or an Open Enrollment Period has occurred. The insurance coordinator must complete an Update Form reporting the employee's transfer.

B. With break in service greater than sixty-three (63) days

Employees who have a break in service greater than sixty-three (63) days are treated as a new employee.

XII Coverage Terminations

A. Termination of Employment

Health insurance coverage for employees terminating employment will be provided through the end of the month following the month of termination subject to the following provisions:

- The employee's contribution will be deducted automatically from the employee's check. In the event there is not enough money in the last paycheck to cover the premium, agencies should collect from the individual or deduct the remainder from the payout of vacation or compensatory pay.
- Employees that terminate before their benefits take effect are not eligible for COBRA.

B. Death of Employee

The employer contribution for health insurance will end the month of the employee's death. If the next month's contribution has been made, a refund must be requested.

- Health insurance ends on the date of death if the employee had no dependents under the Plan.
- Health insurance coverage ends at the end of the month of death if the employee had dependents under the Plan.

At the time of death, the insurance coordinator should notify the family, in writing, of the following:

- date the last paycheck will be issued;
- contact information for the appropriate retirement system;
- name and phone number of health insurance carrier;
- COBRA Election Notice;
- Flexible Spending Account information and phone number (if applicable); and
- any additional employee payroll deductions and company contact.

C. Loss of Dependent Eligibility

Dependent children and/or spouses that become ineligible for coverage under the Plan will be terminated at the end of the month they cease to meet the dependency requirements. You may refer to the Qualifying Event chart in Chapter 3 for the termination dates resulting from Qualifying Events.

XIII Retro Activity Related to Premium

A. Terminations:

Any mid-year election resulting in the termination of a covered person will be effective on the date as designated under the terms of the Public Employee Health Insurance Program. If the DEI receives notification of a termination more than ninety (90) days after the event causing the termination, the premium will be refunded as shown in the following table:

Notification received within the month of:	Count From:	Months for which Premium is to be refunded:
January	January 31	January
February	February 28	January and February
March	March 31	January, February and March
April	April 30	February, March and April
May	May 31	March, April and May
June	June 30	April, May and June
July	July 31	May, June and July
August	August 31	June, July and August
September	September 30	July, August and September
October	October 31	August, September and October
November	November 30	September, October and November
December	December 31	October, November and December

B Overpayment Requirements

Carriers are required to issue refund checks for any erroneous overpayments. Refund checks, except for those to quasi governmental agencies, will be made payable to:

- the Kentucky State Treasurer, if the overpayment is to the employer;
- the employee, if the overpayment is the employee's share; or
- separate checks for both the employee and the Kentucky State Treasurer, if there is an overpayment of both employee and employer payments.

NOTE: Quasi governmental agencies must have specific guidelines with the health insurance carrier in the processing of refund requests.

Refund checks will be sent to the appropriate insurance coordinator or Payroll Officer no later than thirty (30) days from receipt of the request for refund.

Either the insurance coordinator or the Payroll Officer should initiate the request for such refunds. The following list, while not all-inclusive, defines when a refund may be requested:

- A check is issued in error;
- An employee terminates at the end of the month and one-half the premium is deducted and sent to the Carrier;

- An employee is enrolled with the wrong carrier or wrong plan type, option level, or coverage level;
- The occurrence of a Qualifying Event, since the Commonwealth is a pre-paid health plan; or
- An employee is ineligible or becomes ineligible.

Important: Do not take premium credits from your agency account in lieu of refunds.

Refunds will be restricted to the beginning of the current plan year to a maximum period of three (3) months or ninety (90) days, except in the event of the death of a covered person. Premium refunds will be given to the date of death of any covered person.

GENERAL ADMINISTRATION

I Grievance Procedures

A. Appeals to the Health Insurance Carrier

Every health insurance carrier is required by law to print its Grievance Procedures in its Certificate of Coverage that is distributed to every employee enrolled in the Plan. Members should refer to their carrier's Certificate of Coverage for information regarding specific claim appeal and grievance procedures.

B. Appeals to the Public Employee Health Insurance Program's Grievance Committee

Employees who are dissatisfied with a decision regarding enrollment or disenrollment in the Public Employee Health Insurance Program may file a grievance to the Public Employee Health Insurance Program's Grievance Committee. Employees must file the grievance no later than thirty (30) calendar days from the event or notice of the decision being protested.

Grievances must be filed in writing to:

Personnel Cabinet
Department for Employee Insurance
Attention: Grievance Committee
200 Fair Oaks Lane, Suite 502
Frankfort, KY 40601

A grievance must include ALL of the following items:

- name, Social Security number and agency where the member is employed or has coverage;
- a description of the issue(s) disputed by the member;
- a statement of the resolution requested by the member;
- all other relevant information; and
- all supporting documentation.

Grievances without all necessary information will be returned without review.

A written response will be mailed to the employee and to the agency's health insurance coordinator stating the decision of the Committee.

The Committee will not review a second request **unless** additional relevant facts are provided.

II Fraud

If a Carrier believes that any fraudulent activity has occurred, the Carrier is authorized to investigate and resolve issues arising from the fraudulent activity.

III Double Dipping

Employees (or their spouses) that are eligible for and participate in the Public Employee Health Insurance Program as retirees and as employees or spouses, are only permitted to have one employer contribution. They are not allowed to receive a contribution as retirees and a second contribution as employees.

- KRS retirees that have returned to active employment are allowed to select coverage either through KRS or through the active employer.
- KTRS retirees that have returned to active employment must select coverage through the active employer.

Refer to KRS and KTRS for specific information regarding this issue.

IV Health Insurance Portability and Accountability Act of 1996 (HIPAA)

HIPAA is legislation enacted by the federal government to: ensure health insurance portability; reduce health care fraud and abuse; guarantee the integrity and confidentiality of health information; and improve the operations of the health care system.

A. Privacy

HIPAA specifically addresses protecting the privacy of protected health information (PHI). The government has established limitations on the sharing of PHI.

PHI is medical and demographic information that is identifiable to a specific person. Examples of PHI are an individual's address, gender, Social Security number, date of birth, diagnosis or claims history.

B. What is DEI doing to comply with HIPAA?

In the past, the DEI has exchanged electronic mail with members, carriers and coordinators that have contained protected health information needed to identify the member and the issue (Social Security number, address, etc.). Due to the need to comply with HIPAA, the DEI has implemented several changes designed to protect health information used in electronic mail. These changes are applicable to all programs.

When a plan member's information is being transmitted via electronic mail there are two competing interests: (1) The plan member has an expectation that the use of PHI is limited to the minimum necessary to carry out the purpose of the communication; and (2) The employees involved in the communication have an interest in sharing the maximum amount of information permissible to expediently carry out their job function.

In addition to those concerns, electronic mail is considered a public document and is subject to open records requests. One of the DEI's concerns is that PHI transmitted via electronic mail may be inadvertently disclosed to the public through an open records request.

Based on these concerns, the DEI has implemented the following procedures for transmitting member information (PHI or personally identifiable information) to carriers and coordinators via electronic mail:

- Use the word "Confidential" with the member's last name in the subject line (ex. Confidential – Smith).

  This procedure is necessary to ensure that the Commonwealth Office of Technology (COT) can identify all electronic mail to and from this office containing personally identifiable information. If an open records request is made that would include any electronic mail marked confidential, the request will be forwarded to the DEI so that the requested electronic mail may be edited before complying.

- Use the member's last name and the last four (4) digits of the social security number in the text of the electronic mail message to identify the member (ex. Smith-2390). Although the abbreviated information may cause some inefficiency in communication, it is necessary to protect the information regarding members.

- Include only the information necessary to resolve the issue. Currently, insurance coordinators send additional information that may not be relevant, including but not limited to, diagnosis, treatment, prognosis and claims issues. Since the operations of DEI is to procure health insurance on behalf of the Public Employee Health Insurance Program; contract with Third Party Administrators for administration of the flexible spending programs; and provide the eligibility information for both, the above listed information would not be relevant to DEI's scope of operations.

- Beginning January 1, 2004, members of the Public Employee Health Insurance Program have been able to complete and sign an Authorization for Disclosure Form to allow the DEI to disclose information pertaining to eligibility, enrollment, disenrollment and Qualifying Events regarding a member's health plan and/or flexible spending accounts to the member's spouse or dependents. Information pertaining to payment of claims and benefits covered under the health plan must be directed to the health insurance carrier. The authorization forms are on the DEI's Web site. Members may also contact the DEI's Member Services Branch to request a copy of the form.

Members will need to contact their carrier for information relating to payment of claims and which benefits are covered under the member's health plan. If the member needs to have information disclosed from the carrier to someone other than themselves, the carrier may require the member to complete its company's Authorization for Disclosure Form. The Authorization for Disclosure Form completed for the DEI to disclose PHI will not be accepted by the carrier. The

member will be required to abide by the carrier's policies and procedures concerning release of the member's PHI.

V I.D. Cards

- Employees should receive their I. D. card(s) within fourteen (14) days of receipt of enrollment information by the health insurance carrier.
- The policyholder's Social Security Number, or alternate identification number is necessary to process claims.
- Employees may request additional I.D. cards by calling the toll-free number for their carrier listed in the *Health Insurance Handbook*.

NOTE: If a health insurance carrier prints the members' Social Security numbers on the ID cards, the members may contact the carrier to request an ID card without their Social Security number printed on it. Any expenses incurred in the generation of the new ID card will be charged to the member.

Each carrier will provide the I.D. cards, which will designate the plan type, as well as member certificates of coverage describing benefits provided by the plan.

QUALIFYING EVENTS

I Section 125 Cafeteria Plan

The Commonwealth of Kentucky's Public Employee Health Insurance Program is provided through a Section 125 plan. This allows employees to pay for their health insurance premiums with pre-tax monies, which saves them money. Section 125 plans are federally regulated. Federal guidelines state that if employees' health insurance is offered through a Section 125 plan, **they cannot make a change in their health insurance options outside of the Open Enrollment period unless they experience an appropriate Qualifying Event.** Qualifying Events are also governed by federal guidelines and the Department for Employee Insurance cannot modify the Qualifying Events it has adopted for use in this Program.

II Changes in Coverage During the Open Enrollment Period

All changes are permitted during Open Enrollment with the following exception:

- employees cannot drop dependent children for whom they are required by an administrative order to provide coverage if enforcement of the order is directed to the employer.

III Qualifying Event Chart

Personnel Cabinet

The Office of Public Employee Health Insurance

Permitted Mid-Year Election Changes

This chart reflects the mid-year election changes permitted in health insurance for the entire group and the changes permitted in the Health FSA and Dependent Care FSA for Commonwealth Choice participants.

This chart describes the election changes that a cafeteria plan can permit employees to make during a period of coverage under the final cafeteria plan regulations issued in March 2000 and January 2001. Although some of the regulatory provisions are ambiguous, this chart reflects our views of permitted election changes, which are adopted for the Plan Year 2003. The only required mid-year election changes are those related to loss of eligibility (death, divorce, loss of dependency and age.)

Also note that pending future guidance, it appears employers can still rely on a 1989 proposed regulation (1.125-2, q&a-6 (e), renumbered as q&a-6(b)) to allow employees to drop cafeteria plan coverage mid-year if they remain out for the rest of the year.

Event	Accident or Health Plan Covering Expenses of Employee, Spouse, Eligible Dependents	Commonwealth Choice Health FSA Covering Expenses of Employee, Spouse, Dependents	Commonwealth Choice Dependent Care FSA
Change in Legal Marital Status			
Marriage	Add employee and/or spouse and dependents Or →→→ --- Drop employee/dependents if person becomes covered under spouse's plan	Start or increase election Or →→→ --- Decrease election if family members become covered under spouse's health plan (2)	Start or increase election if marriage increases dependent care expenses (3) Or --- Stop or decrease election if family elects dependent care assistance under spouse's plan or marriage decreases dependent care expenses (3)
Divorce, legal separation, annulment	Add employee and dependents (1) if event causes loss of coverage under spouse's plan, or --- Drop spouse; also drop family members added to former spouse's plan	Start or increase election if event causes loss of coverage under spouse's health plan (2) or Stop election and redirect the state contribution to health insurance if the event causes loss of other coverage for the employee or --- Decrease election	Start or increase election if event increases dependent care expenses (3) or causes loss of coverage under spouse's plan or Stop or decrease election if event decreases dependent care expenses (3)
Spouse's death	Add employee and any dependent who loses coverage under spouse's plan,	Start or increase election if death causes loss of coverage under spouse's health plan (2) or	Start or increase election if death causes loss of coverage under spouse's plan or increases dependent care expenses (3)

Event	Accident or Health Plan Covering Expenses of Employee, Spouse, Eligible Dependents	Commonwealth Choice Health FSA Covering Expenses of Employee, Spouse, Dependents	Commonwealth Choice Dependent Care FSA
	or --- Drop spouse	Stop election and redirect the state contribution to health insurance if the event causes loss of other coverage for the employee or --- Decrease election	or --- Stop or decrease election if death decreases dependent care expenses (3)
Change in Number of Dependents			
Number of employee's eligible dependents increases (by birth, adoption, or placement for adoption)	Add employee and/or spouse and/or other dependents (1)	Start or increase election	Start or increase election if employee has greater dependent care expenses
Number of employee's eligible dependents decreases (e.g., by death or because child becomes ineligible)	Drop affected dependent	Decrease election	Stop or decrease election if employee has reduced dependent care expenses
Change in Employee's Employment Status			
Employee terminates employment	Cease contributions	Cease contributions	Cease contributions
Employee is rehired less than 63 days after termination of employment	Reinstate prior election unless intervening status change event (9)	Reinstate prior election unless intervening status change event (9) If employee did not elect COBRA during termination period, reinstatement of the prior coverage can be accomplished with one of the following	Reinstate prior election unless intervening status change event (9)

Event	Accident or Health Plan Covering Expenses of Employee, Spouse, Eligible Dependents	Commonwealth Choice Health FSA Covering Expenses of Employee, Spouse, Dependents	Commonwealth Choice Dependent Care FSA
		methods (employee's choice): Proration: Employee may elect to continue at the same monthly contribution as prior to the termination and the annual amount is reduced by the contributions missed during that period or Reinstatement: Employee may elect to makeup the shortfall resulting from the contributions missed during the terminated period	
Employee is rehired more than 63 days after termination of employment	Make election to same extent permitted as new employee	Make election to same extent permitted as new employee	Make election to same extent permitted as new employee
Employee commences official leave without pay	Cease contributions	Cease contributions	Cease contributions
Employee returns from official leave without pay	Reinstate prior election unless intervening status change event (9)	Reinstate prior election unless intervening status change event (9) Reinstatement of the prior coverage can be accomplished with one of the following methods (employee's choice):	Reinstate prior election or Change election if event changes dependent care expenses (3)

Event	Accident or Health Plan Covering Expenses of Employee, Spouse, Eligible Dependents	Commonwealth Choice Health FSA Covering Expenses of Employee, Spouse, Dependents	Commonwealth Choice Dependent Care FSA
		Proration: Employee may elect to continue at the same monthly contribution as prior to the termination and the annual amount is reduced by the contributions missed during that period or Reinstatement: Employee may elect to makeup the shortfall resulting from the contributions missed during the terminated period	
Employee begins unpaid FMLA leave (4) or Military Leave	Cease contributions or Prepayment: Employee may increase election to prepay coverage contributions for FMLA leave period or Pay-as-you-go: Employee may make contributions on the same schedule as payments would have been made otherwise	Cease contributions or Prepayment: Increase election to prepay coverage during leave or Pay-as-you-go: Employee may make contributions on the same schedule as payments would have been made otherwise	Decrease election if leave causes loss of coverage or decreases dependent care expenses (3) or Cease contributions

Event	Accident or Health Plan Covering Expenses of Employee, Spouse, Eligible Dependents	Commonwealth Choice Health FSA Covering Expenses of Employee, Spouse, Dependents	Commonwealth Choice Dependent Care FSA
*NOTE: Employee may choose not to participate; otherwise they must choose one payment option or another	or Catch-Up Option: If agreed to by both parties PRIOR to the FMLA leave, the employer may make contributions on behalf of the employee and may recoup the contributions upon the employee's return to employment		
Employee returns from unpaid FMLA leave (4) or Military Leave	Reinstate prior election unless intervening status change event (9) NOTE: Employees returning from Military Leave are eligible	Employee must be able to reinstate prior coverage and can choose one of the following: Proration: Employee may elect to continue at the same monthly contribution as prior to the FMLA and the annual amount is reduced by the contributions missed during the FMLA or Reinstatement: Employee may elect to makeup the shortfall resulting from the contributions missed during FMLA	Generally same rights as employee returning from non-FMLA leave, though employee must be able to reinstate prior coverage

Event	Accident or Health Plan Covering Expenses of Employee, Spouse, Eligible Dependents	Commonwealth Choice Health FSA Covering Expenses of Employee, Spouse, Dependents	Commonwealth Choice Dependent Care FSA
	for coverage immediately upon return or may delay the effective date until military coverage ends (employee's option)		
Employee commences paid leave (assuming event does not affect eligibility for coverage)	No change	No change	Decrease election if event decreases dependent care expenses (3)
Employee returns from paid leave	No change unless intervening status change event (9)	No change unless intervening status change event (9)	Increase election if event increases dependent care expenses (3)
Employee changes worksite (out of service area) *This is only applicable if the employee chose "work" county	Make election changes that correspond with event	No change	Decrease election if event decreases dependent care expenses (3) or Increase election if event increases dependent care expenses (3) (unless the care provider is a relative)
Other change in employee's employment status (e.g., switch from salaried to hourly status) that causes employee to cease eligibility under plan	Cease contributions	Cease contributions	Cease contributions
Other change in employee's employment status (e.g., switch from hourly to salaried status) that causes employee to become eligible for coverage under plan	Make elections as if a new employee, unless there was less than a 63-day break in eligibility.	Make elections as if a new employee	Make elections as if a new employee
Change in Spouse or Dependent Employment Status (Dependent must continue to meet all eligibility requirements.)			

Event	Accident or Health Plan Covering Expenses of Employee, Spouse, Eligible Dependents	Commonwealth Choice Health FSA Covering Expenses of Employee, Spouse, Dependents	Commonwealth Choice Dependent Care FSA
Spouse or dependent terminates employment	Add employee, spouse, and dependents (1) if event adversely affects eligibility for coverage under spouse's or dependent's health plan	Start or increase election if event adversely affects eligibility for coverage under spouse's or dependent's health plan (2)	Start or increase election if event adversely affects eligibility for coverage under spouse's dependent care assistance plan or Stop or decrease election if event decreases dependent care expenses (3)
Spouse or dependent commences employment	Drop employee, spouse, or dependent who becomes covered under spouse's or dependent's plan	Decrease election if family becomes covered under health plan of spouse or dependent (2)	Start or increase election if event increases dependent care expenses (3) or Stop or decrease election if family becomes covered under spouse's dependent care assistance plan
Spouse or dependent is out of work due to strike or lockout	Add employee, spouse, and dependents (1) if event adversely affects eligibility for coverage under health plan of spouse or dependent	Start or increase election if event adversely affects eligibility for coverage under spouse's or dependent's health plan (2)	Start or increase election if event adversely affects eligibility for coverage under spouse's dependent care assistance plan or Stop or decrease election if event decreases dependent care expenses (3)
Spouse or dependent returns to work following cessation of strike or lockout	Drop employee, spouse, or dependent who becomes covered under spouse's or dependent's health plan	Decrease election if family becomes covered under health plan of spouse or dependent (2)	Start or increase election if event increases dependent care expenses (3) or Stop or decrease election if family becomes covered under spouse's dependent care assistance plan

Event	Accident or Health Plan Covering Expenses of Employee, Spouse, Eligible Dependents	Commonwealth Choice Health FSA Covering Expenses of Employee, Spouse, Dependents	Commonwealth Choice Dependent Care FSA
Spouse or dependent commences unpaid leave (if the event adversely affects eligibility for coverage under the spouse or dependent's plan)	Add employee, spouse, and dependent (1)	Start or increase election if event adversely affects eligibility for coverage under spouse's or dependent's health plan (2)	Start or increase election if event adversely affects eligibility for coverage under spouse's dependent care assistance plan or Stop or decrease election if event decreases dependent care expenses (3)
Spouse or dependent returns from unpaid leave	Drop employee, spouse, or dependent who becomes covered under spouse's or dependent's health plan	Decrease election if family becomes covered under spouse's or dependent's health plan (2)	Start or increase election if event increases dependent care expenses (3) or Stop or decrease election if family becomes covered under spouse's dependent care assistance plan
Other change in spouse's or dependent's employment status that causes spouse or dependent to cease to be eligible for coverage under spouse's or dependent's plan (e.g., switch from salaried to hourly status)	Add employee, spouse, and dependent (1)	Start or increase election (2)	Start or increase election if event adversely affects eligibility for coverage under spouse's plan (3)
Other change in employment status that causes spouse or dependent to gain eligibility for coverage under spouse's or dependent's plan (e.g., switch from hourly to salaried status)	Drop coverage for employee, spouse, or dependent who becomes covered under spouse's or dependent's plan	Decrease election if family members become covered under health plan of spouse or dependent (2)	Decrease election or Increase election if event increases dependent care expenses (3)
Change in Dependent Eligibility			

Event	Accident or Health Plan Covering Expenses of Employee, Spouse, Eligible Dependents	Commonwealth Choice Health FSA Covering Expenses of Employee, Spouse, Dependents	Commonwealth Choice Dependent Care FSA
Dependent ceases to satisfy plan eligibility requirements on account of age, marriage or any similar circumstance (support and maintenance)	Drop coverage for dependent	Decrease election	Stop or decrease election if event decreases dependent care expenses (3)
Unmarried dependent re-establishes plan eligibility requirement (5) under applicable plan	Add dependent who satisfies plan eligibility requirement	Start or increase election	Start or increase election if event increases dependent care expenses (3)
Change in Residence			
Employee, spouse, or dependent changes primary (6) residence and becomes ineligible for current benefit election	Make election change that corresponds with event	Make election change that corresponds with event	Make a corresponding election change if the child care provider changes
Other Events			
Loss of other group health insurance coverage that entitles employee or family member to be enrolled under HIPAA	Add employee (1) or ---------- Add spouse and/or dependent	Start or increase election or Stop election and redirect the state contribution if the event causes loss of other coverage for the employee or ---------- Start or increase election	None
Judgment, decree, or administrative order relating to health coverage for child	Add child if required under order or ----------	Start or increase election if order requires employee to provide child's health coverage or ----------	None

Event	Accident or Health Plan Covering Expenses of Employee, Spouse, Eligible Dependents	Commonwealth Choice Health FSA Covering Expenses of Employee, Spouse, Dependents	Commonwealth Choice Dependent Care FSA
	Drop child if other parent provides coverage under order	Decrease election if other parent covers child under order	
Employee, spouse, or dependent enrolled in employer's health plan becomes entitled to Medicare or Medicaid	Make an election change that corresponds to the event	Decrease election	None
Employee, spouse, or dependent loses entitlement to Medicare, Medicaid, KCHIP, any governmental group health insurance coverage	Commence or increase coverage of that employee, spouse, or dependent	Start or increase election	None
Cost or Coverage Changes (8)			
Change in Cost			
Benefit option has significant increase or decrease in cost			Make a corresponding change (increase or decrease). Increasing the election for a day care provider raising rates mid-year is only permitted if the provider is not a relative of the employee
Change In Coverage Under Another Employer Plan			
Employee's spouse makes elections during an open enrollment period that differs from the open enrollment period of the employer (7) --- Employee makes elections during an open enrollment period of another employer that differs	Employee can make election change that "corresponds" with spouse's election change --- Employee can make election change that corresponds with the elections made with the other employer's plan	After Open Enrollment and before 12/31 Employee may make corresponding change (and redirect state contribution) After 12/31 - None --- After Open Enrollment and before 12/31	Employee can make election change that "corresponds" with election change under the other employer plan

Event	Accident or Health Plan Covering Expenses of Employee, Spouse, Eligible Dependents	Commonwealth Choice Health FSA Covering Expenses of Employee, Spouse, Dependents	Commonwealth Choice Dependent Care FSA
from the open enrollment period of the employer (7) --- Retiree makes elections during an open enrollment period of a state sponsored retirement system that differs from the open enrollment period of the employer	--- Retiree can make an election change that corresponds with the elections made with the retirement system plan	Employee may make corresponding change (and redirect state contribution) After 12/31 – None --- None	
Individual changes election for any other event that is permitted under regulation (and terms of the employer plan)	Employee can make election change that "corresponds" with election change	None	Employee can make election change that "corresponds" with election change

Permitted Election Changes

End Notes:

(1) The final regulation preamble indicates that dependents who can be added are those who were directly affected by the status change event plus other dependents (the so-called "tag-along" rule). However, the examples in the regulation only explicitly deal with situations where an employee elects family coverage and adds family members at no additional cost. It is not clear, but IRS staff members have informally stated that the "tag-along" rule applies even if the employee must increase an election to add additional dependents. Also, the preamble and examples in the regulation indicate that the "tag-along" rule applies to HIPAA events and situations where a spouse terminates employment; it is not clear what other events might be covered by the "tag-along" rule.

(2) It appears this rule does not require that a spouse's coverage include a Health FSA.

(3) By an increase or decrease in dependent care expenses, we mean that the event increases or decreases the amount of expenses that an employee can have reimbursed on a tax-free basis under Code section 129 from a dependent care assistance plan. For example, if the employee gets married and his or her spouse does not work outside the home, the spouse would be available to care for a child, and thus the employee may not be able to claim that dependent care expenses are being used to enable the employee to be gainfully employed — a condition that must be satisfied for the

expense to be reimbursed on a tax-free basis under Code section 129. Conversely, the marriage can increase the amount of expenses reimbursable under the dependent care assistance plan if, for example, a new spouse or stepchild is a "qualifying individual" for whom dependent care assistance can be received. A spouse's death or divorce might lead to fewer dependent care expenses eligible for reimbursement under section 129 if, for example, the spouse was a "qualifying individual." Conversely, if the spouse was not employed outside the home, the death or divorce might require the employee to pay for a caregiver in order to remain gainfully employed, and therefore the expenses may be reimbursed on a tax-free basis under section 129.

(4) Most employees are entitled to certain rights under the Family and Medical Leave Act (FMLA), whether or not the benefits are provided through a cafeteria plan. Employees generally must receive up to 12 weeks of unpaid FMLA leave, although the employee or employer generally can choose to substitute available paid leave for unpaid leave. During FMLA leave, the employer must maintain group health coverage (including FSA coverage) on the same conditions as coverage would be provided if the employee had not taken the leave. An employee's entitlement to other benefits during FMLA leave is determined by the employer's established policy for providing such benefits when the employee is on other forms of paid or unpaid leave (as appropriate). If benefits are continued during unpaid leave, proposed IRS regulations allow benefits purchased through a cafeteria plan to be paid in several ways, including increased salary reductions before the leave to prepay benefits or using salary reductions after the leave to "catch-up" on payments. Benefits continued on paid FMLA leave are paid for in the same manner as during any paid leave. Employees can choose to drop benefits while on leave, but FMLA requires they have the right to be reinstated upon return from leave.

(5) For purposes of eligibility in this plan, a divorced dependent is not an "unmarried" dependent.

(6) Primary residence is the official residence claimed for tax purposes.

(7) Military Insurance Coverage, which does not include Veteran's Administration benefits, is considered "Another Employer Plan".

(8) "Cost or Coverage Changes Under the Employer's Plan" are not included in this chart. In the event there is a mid-year change in the Commonwealth's plan(s), specific direction will be provided to the group or groups affected.

(9) The same status change rules apply – an employee must request the mid-year election change within the required time limits for such requests (30 days from the event except for adding a newborn (only), which is 60 days.

Effective Dates

Effective dates for the various mid-year election changes are as follows:

A. Events increasing coverage

1. Birth, adoption, placement for adoption = date of the event;
2. Marriage, loss of other coverage, court or administrative orders for dependent(s) or foster child(ren), expiration of COBRA = 1st day 1st month from the employee signature date.
3. Different Open Enrollment = 1st day 1st month

B. Events decreasing coverage

1. Death = date of the event.
2. Divorce, loss of dependent status or moving out of the service area = End of the month of loss of eligibility.
3. Gaining other health insurance coverage (Medicare/Medicaid/Tricare/etc.) = End of the month from the employee's signature date.
4. Different Open Enrollment = End of the month from the employee's signature date.

The application is not to be signed BEFORE the Qualifying Event date, EXCEPT for loss of other coverage.

NOTE: No option changes (A to B, B to A, etc.) are permitted when adding and dropping dependents.

IV Effective Dates

A. Adding Dependents

In order to add dependents to the Plan, employees must experience a Qualifying Event such as marriage, birth, adoption, loss of group coverage, etc. The effective date will be the first day of the first month after the employee's signature on the application or Add form, except for birth (effective on the date of birth) and adoption or placement for adoption (effective on the date of adoption or placement for adoption). The application or Add form must be signed and dated by the employee within the specified deadline. Employees are responsible for any premiums due, including arrears.

B. Dropping Dependents

In order to drop dependents from the Plan, employees must experience a Qualifying Event such as divorce, dependent ineligibility, death, gaining other group coverage, Medicare eligibility, etc. The effective date will be the last day of the month in which the employee signs the Drop form, except for loss of eligibility or dependent status (effective the last day of the month in which they become ineligible). The Drop form must be signed and dated by the employee within the specified deadline. The insurance coordinator may request a refund from the health insurance carrier if a premium refund is due.

V. Qualifying Events – Specific Information

After the Open Enrollment period, employees must experience a Qualifying Event (as listed in the Qualifying Event Chart) to add or drop dependents or, under appropriate circumstances, make other permitted changes. Unless otherwise indicated in the following explanations, if there is a discrepancy between the *Specific Information* below and the preceding Qualifying Event chart, the information in the Qualifying Event chart prevails.

VI General Guidelines Regarding Qualifying Events

- Requests for changes due to Qualifying Events cannot be signed before the event takes place; except for Loss of Other Group Health Coverage, Entitlement to Medicare and Spouse's Different Open Enrollment Period - *Revised March 2004* (supersedes information on the Qualifying Event chart).

- The Qualifying Event date is the date the event takes place and not the date the employees or dependents are notified of the event. The DEI will accept notification date only for Entitlement to CHAMPVA, TRICARE, and governmental programs such as Medicare and Medicaid. *Revised March 2004* (supersedes information on the Qualifying Event chart).

- Refunds for overpayment of premiums have a time limitation. If the DEI receives notification of a change more than ninety (90) days after the event, premiums will be refunded as defined in Chapter 1 under *Retro Activity Related to Premiums*.

For purposes of determining the thirty (30) or sixty (60) day deadline for Qualifying Events, the GHI system counts thirty (30) or sixty (60) calendar days beginning on the day after the Qualifying Event.

A. Change in Legal Marital Status

1. Marriage

- **What can employees do?**
  - Add themselves and their spouse and eligible dependent children;
  - add their spouse and dependent children;
  - add their spouse only;
  - drop themselves if they become covered under the spouse's group plan; or
  - drop their dependent children if they become covered under the spouse's group plan.

- **Effective Date**
  - If adding – first day of the month following the employee's signature on the application or Add Form.
  - If dropping – end of the month of the employee's signature on the Drop Form.

- **Deadline**

  Thirty (30) days from the event date.

- **Supporting Documentation Needed:**

  None

2. Divorce, Legal Separation, Annulment

- **What can employees do?**
  - Drop dependent children if they cease to meet the eligibility requirements under the Public Employee Health Insurance Program – *REQUIRED;*
  - drop former spouse only – *REQUIRED;*
  - drop dependent children <u>if they are added to former spouse's group plan; and</u>
  - add themselves and their dependent children <u>if the event causes loss of coverage under the former spouse's group plan;</u>

- **Effective Date**

  - If adding – first day of the month following the employee's signature on the application or Add form.
  - If dropping former spouse– end of the month of the divorce, legal separation or annulment
  - If dropping dependent children that were added to former spouse's group plan – end of the month of the employee's signature on the Drop form.

- **Deadline**

  Thirty (30) days from the event date. This Qualifying Event makes the former spouse ineligible to participate in the Public Employee Health Insurance Program; therefore, the former spouse must be dropped from the plan at the end of the month of ineligibility.

- **Supporting Documentation Needed**

  - To add themselves and their dependent children if the event causes loss of other group coverage
    - Filed decree signed by a judge and date-stamped "filed", at the discretion of the DEI, AND
    - proof that they were covered under their former spouse's plan and no longer eligible (such as HIPAA certificate or letter from employer showing date of insurance termination and the names of the persons previously covered under the policy)
  - To drop the former spouse only - Filed decree signed by a judge and date-stamped "filed"
  - To drop dependent children if they are added to former spouse's group plan - Filed decree signed by a judge and date-stamped "filed", at the discretion of the DEI
  - To drop dependent children that cease to meet dependent eligibility requirements under the Public Employee Health Insurance Program - Filed decree signed by a judge and date-stamped "filed", at the discretion of the DEI

3. Spouse's Death

- **What can employees do?**

  - Add themselves and their dependent children that have lost coverage under the spouse's group plan.
  - Drop spouse from plan.

- **Effective Date**

  - If adding – first day of the month following the employee's signature on the application or Add form

- If dropping spouse– spouse's date of death. The new plan will be effective on the day following the date of death.

- **Deadline**

  - If adding - Thirty (30) days from the date of loss of other group coverage.
  - If dropping, upon notification of the dependent's death, the deceased dependent termination will be processed even if the thirty (30) day deadline is not met

- **Supporting Documentation Needed**

  - To add themselves and their dependent children <u>if the event causes loss of other group coverage</u> - Proof that they were covered under their spouse's plan (such as HIPAA certificate or letter from employer showing date of insurance termination and the names of the persons previously covered under the policy)
  - To drop the deceased spouse - None

- **Other**

  Employees that experience this Qualifying Event may be eligible for a premium refund.

  - If the event date is between the 1st and the 15th of a month, the employee will be entitled to any refund for the month of death resulting from a plan level change (Family to Parent Plus or Couple to Single)
  - If the event date is between the 16th and the end of a month, the employee will not be entitled to any refund resulting from a plan level change (Family to Couple or Couple to Single) due to the spouse's death

B Change in Number of Dependents - Adding

1. Birth – Newborn Only

- **What can employees do?**

  - Add their newborn child(ren)

- **Effective Date:**

  - The child's date of birth. The new plan will be effective on the child's date of birth

- **Deadline**

  - Sixty (60) days from the child's date of birth

- **Supporting Documentation Needed**

  - None

- **Other**

  Employees that experience this Qualifying Event and whose coverage level will change due to the event (Single to Parent Plus or Couple to Family), will submit premium payments as follows:

  - If the child is born between the 1st and the 15th of the month, the employee will be responsible for payment of premiums for the entire month at the new coverage level
  - If the child is born between the 16th and the end of the month , the employee will not be responsible for payment of premiums for the birth month at the new coverage level

2. Birth Plus – Adding the Newborn and Other Dependents

- **What can employees do?**

  - Add themselves, their newborn child(ren), other dependent children, and their spouse;
  - add their newborn child(ren), other dependent children and the spouse;
  - add their newborn child(ren) and other dependent children; or
  - add their newborn child(ren) and the spouse.

- **Effective Date**

  The newborn child's date of birth. The new plan will be effective on the newborn child's date of birth

- **Deadline**

  Thirty (30) days from the newborn child's date of birth

- **Supporting Documentation Needed**

  None

- **Other**

  Employees that experience this Qualifying Event and whose coverage level will change due to the event (Single to Parent Plus or Couple to Family), will submit premium payments as follows:

  - If the child is born between the 1st and the 15th of the month, the employee will be responsible for payment of

premiums for the entire month at the new coverage level

- If the child is born between the 16th and the end of the month , the employee will not be responsible for payment of premiums for the birth month at the new coverage level

3. Adoption or Placement for Adoption – Adding the Newly Placed or Adopted Child(ren) Only

- **What can employees do?**

  Add their newly placed or adopted child(ren)

- **Effective Date**

  The date of adoption or the date of placement for adoption. The new plan will be effective on the adoption date or the date of placement for adoption

- **Deadline**

  Sixty (60) days from the adoption date or the date of placement for adoption

- **Supporting Documentation Needed**

  - Papers from the Cabinet for Families and Children; or
  - Signed and date-stamped "filed" papers from the Court; or
  - Letter from adoption agency on letterhead; or
  - Legal document from a US Court; or
  - Official documentation translated into English, if applicable.

- **Other**

  Employees that experience this Qualifying Event and whose coverage level will change due to the event (Single to Parent Plus or Couple to Family), will submit premium payments as follows:

  - If the child is adopted or placed for adoption between the 1st and the 15th of the month, the employee will be responsible for payment of premiums for the entire month at the new coverage level
  - If the child is adopted or placed for adoption between the 16th and the end of the month , the employee will not be responsible for payment of premiums for the month of adoption or placement for adoption at the new coverage level

4. Adoption or Placement for Adoption – Adding the Newly Placed or Adopted Child(ren) and Other Dependents (Birth Plus)

- **What can employees do?**

  - Add themselves, their newly placed or acopted child(ren), other dependent children or their spouse;
  - add their newly placed or adopted child(ren), other dependent children and the spouse;
  - add their newly placed or adopted child(ren) and other dependent children; or
  - add their newly placed or adopted child(ren) and the spouse.

- **Effective Date**

  The newly placed or adopted child's date of placement or adoption. The new plan will be effective on the placement date or the date of adoption.

- **Deadline**

  Thirty (30) days from the placement or adoption date

- **Supporting Documentation Needed**

  - Papers from the Cabinet for Families and Children; or
  - Signed and date-stamped "filed" papers from the Court; or
  - Letter from adoption agency on letterhead; or
  - Legal document from a US Court; or
  - Official documentation translated into English, if applicable.

- **Other**

  Employees that experience this Qualifying Event and whose coverage level will change due to the event (Single to Parent Plus or Couple to Family), will submit premium payments as follows:

  - If the child is adopted or placed for adoption between the 1st and the 15th of the month, the employee will be responsible for payment of premiums for the entire month at the new coverage level
  - If the child is adopted or placed for adoption between the 16th and the end of the month , the employee will not be responsible for payment of premiums for the month of adoption or placement for adoption at the new coverage level

C. Change in Number of Dependents - Dropping

1. Death of a Dependent Child (For information regarding death of a spouse, see "*Spouse's Death"* under *Change in Legal Marital Status* above)

- **What can employees do?**

  Drop the deceased dependent

- **Effective Date**

  - Coverage of the deceased dependent will end on the dependent's date of death.
  - If the dependent's death causes a plan level change (Parent Plus to Single or Family to Couple), the new plan will be effective on the day following the dependent's date of death

- **Deadline**

  Thirty (30) days from the dependent's date of death. Upon notification of the dependent's death, the deceased dependent termination will be processed even if the thirty (30) day deadline is not met

- **Supporting Documentation Needed**

  None

- **Other**

  Employees that experience this Qualifying Event may be eligible for a premium refund.

  - If the event date is between the 1st and the 15th of a month, the employee will be entitled to any refund for the month of death resulting from a plan level change (Parent Plus to Single or Family to Couple)
  - If the event date is between the 16th and the end of a month, the employee will not be entitled to any refund resulting from a plan level change (Parent Plus to Single or Family to Couple) due to the dependent's death

2. Dependent Child Becomes Ineligible (Ceases to meet the eligibility requirements under the Public Employee Health Insurance Program**)**

- **What can employees do?**

  Drop the ineligible dependent - *REQUIRED*

- **Effective Date**

  The ineligible dependent's coverage will end at the end of the month in which the dependent becomes ineligible (date of dependent's marriage, date of change in primary residence, attaining the limiting age, etc.)

- **Deadline**

  Thirty (30) days from the event date. This Qualifying Event makes the dependent ineligible to participate in the Public Employee Health Insurance Program; therefore, the ineligible dependent will be dropped from the plan at the end of the month of ineligibility even if the thirty (30) day deadline is not met

- **Supporting Documentation Needed**

  - In most cases – none
  - The DEI reserves the right to request supporting documentation. The insurance coordinator will be notified if supporting documentation is needed.

D. Change in Employee's Employment Status

1. Employees Terminate Employment – See *Terminations* in Chapter 1,

2. Employees are Rehired Less than 63 Days After Termination of Employment – See *Transfers and Rehires* in Chapter 1

3. Employees are Rehired 63 Days or More After Termination of Employment – See *Transfers and Rehires* in Chapter 1.

4. Employees Commence Official Leave Without Pay (LWOP) – See *Leave Without Pay (LWOP)* in Chapter 6.

5. Employees Return from Official Leave Without Pay (LWOP) – See *Leave Without Pay (LWOP)* in Chapter 6.

6. Employees Commence FMLA Leave – See *Family Medical Leave Act (FMLA)* in Chapter 6.

7. Employees Return from FMLA Leave – See *Family Medical Leave Act (FMLA)* in Chapter 6.

8. Employees Commence Military Leave – See *Military Leave* in Chapter 6.

9. Employees Return from Military Leave – See *Military Leave* in Chapter 6.

10. Employees Commence Paid Leave – See *Paid Leave* in Chapter 6.

11. Employees Return from Paid Leave – See *Paid Leave* in Chapter 6.

E. Employees Move Out of the Service Area (Residence or Work County)

Moving out of the service area allows employees to make a new carrier selection, depending on the employees' choice to select coverage in their home county, work county, or contiguous county, if applicable. This occurs when employees move out of their selected county of coverage into another county where their existing carrier is not available. For instance, if employees select their coverage in their home county and their residence changes to another county, they may be eligible to change carriers. If employees selected coverage in their work county and their work county changes, they may also be eligible to change carriers.

- **What can employees do?**

  - If employees have coverage in their **home** county and they move their residence to a different county in which their carrier is not available, the employees will be able to:
    - Change their current carrier to a carrier that is available in the new home county; or
    - Change their county of coverage from home to work in order to keep their current carrier (providing that the current carrier is available in their work county).
  - If employees have coverage in their **work** county and they move their residence to a county where their current carrier is not available, the employees will not be allowed to change carriers because their carrier is still available in their county of choice (work).

  Changes in coverage options during the Plan Year are not allowed.

- **Effective Date**

  First day of the month following the employee's signature date on the application.

  In Plan Year 2005, only one health insurance carrier is available per geographic region. Upon receipt of an address change request, the DEI will process the request and will notify the health insurance carrier of the required change in health insurance carriers. In some instances, address change notifications that require a carrier change are received by the DEI on an update form. The update form will be acceptable.

- **Deadline**

  Thirty (30) days from the event. However, if employees fail to notify the insurance coordinator of an address change that causes a move out of the service area, the Qualifying Event will be processed even if the thirty (30) day deadline is not met

- **Supporting Documentation Needed**

  None

F. Change in Spouse or Dependent Employment Status

1. Spouse Loses Other Employer-Sponsored Group Health Coverage (termination of employment, strike or lockout, commencement of unpaid leave, loss of eligibility under the employer's plan, etc.)

- **What can employees do?**

  Add themselves, spouse and dependents if the event adversely affects eligibility for coverage under spouse's health plan (loss of employer-sponsored group health coverage)

- **Effective Date**

  First day of the month following the employee's signature date on the application or Add form

- **Deadline**

  Thirty (30) days from the Qualifying Event date. The Qualifying Event date is the date the added members lose coverage under the spouse's employer-sponsored group health plan

  The application or Add form may be signed by the employee prior to the loss of coverage. *Revised March 2004* (supersedes information on the Qualifying Event chart).

- **Supporting Documentation Needed**

  - HIPAA certificate of prior coverage; or
  - Letter from employer/previous employer. The letter must be typed on company letterhead and it must identify the date of coverage termination and the persons who were covered by the policy

2. Spouse Gains Other Employer-Sponsored Group Health Coverage (by commencing employment, returning to work after a strike or lockout, returning from unpaid leave, gaining eligibility under the employer's plan, etc.)

- **What can employees do?**

  Drop coverage for them, their spouse and dependents if they become covered under the employer's plan (gaining employer-sponsored group health coverage)

- **Effective Date**

  Last day of the month in which the employee signs the Drop form

- **Deadline**

  Thirty (30) days from the Qualifying Event date. The Qualifying Event date is the date the dropped members gain coverage under the spouse's employer-sponsored group health plan

- **Supporting Documentation Needed**

  None

3. **Dependent (other than spouse) Loses Other Employer-Sponsored Group Health Coverage** (termination of employment, strike or lockout, commencement of unpaid leave, loss of eligibility under the employer's plan, etc.)

   - **What can employees do?**

     Add their dependents (other than spouse) if they meet all eligibility requirements under the Public Employee Health Insurance Program

   - **Effective Date**

     First day of the month following the employee's signature date on the Add form

     The Add form may be signed by the employee prior to the loss of coverage. *Revised March 2004* (supersedes information on the Qualifying Event chart).

   - **Deadline**

     Thirty (30) days from the Qualifying Event date. The Qualifying Event date is the date the added members lose coverage under the dependent's employer-sponsored group health plan

   - **Supporting Documentation Needed**

     - HIPAA certificate of prior coverage; or
     - Letter from employer/previous employer. The letter must be typed on company letterhead and it must identify the date of coverage termination and the persons who were covered by the policy

4. **Dependent (other than spouse) Gains Other Employer-Sponsored Group Health Coverage** (by commencing employment, returning to work

after a strike or lockout, returning from unpaid leave, gaining eligibility under the employer's plan, etc.)

- **What can employees do?**

  Drop coverage for the dependent gaining coverage under the employer's plan (gaining employer-sponsored group health coverage)

- **Effective Date**

  Last day of the month in which the employee signs the Drop form

- **Deadline**

  Thirty (30) days from the Qualifying Event date. The Qualifying Event date is the date the dropped dependents gain coverage under the dependent's employer-sponsored group health plan

- **Supporting Documentation Needed**

  None

G. Change in Dependent Eligibility

1. **Dependent Ceases to Satisfy Plan Eligibility Requirements** (on account of age, marriage, support and maintenance, etc.)

   - **What can employees do?**

     Drop the ineligible dependent - *REQUIRED*

   - **Effective Date**

     The ineligible dependent's coverage will end at the end of the month in which the dependent becomes ineligible (date of dependent's marriage, date of change in primary residence, attaining the limiting age, etc.)

   - **Deadline**

     Thirty (30) days from the event date. This Qualifying Event makes the dependent ineligible to participate in the Public Employee Health Insurance Program; therefore, the ineligible dependent will be dropped from the plan at the end of the month of ineligibility even if the thirty (30) day deadline is not met

- **Supporting Documentation Needed**

  - In most cases – none
  - The DEI reserves the right to request supporting documentation. The insurance coordinator will be notified if supporting documentation is needed.

2. Unmarried Dependent Re-establishes Plan Eligibility Requirements

- **What can employees do?**

  Add dependents that re-establish the eligibility requirements under the Public Employee Health Insurance Program

- **Effective Date**

  First day of the month following the employee's signature date on the Add form

- **Deadline**

  Thirty (30) days from the Qualifying Event date.

- **Supporting Documentation Needed**

  None

H. Change in Residence

1. Employee Changes Residence or Work County - See *Employee Moves Out of the Service Area (Residence or Work County)* under *Change in Employee's Employment Status* in this Chapter.

Moving out of the service area allows employees to make a new carrier selection, depending on the employees' choice to select coverage in their home county, work county, or contiguous county, if applicable. This occurs when employees move out of their selected county of coverage into another county where their existing carrier is not available.

- **What can employees do?**

  - If employees have coverage in their **home** county and they move their residence to a different county in which their carrier is not available, the employees will be able to:
    - Change their current carrier to a carrier that is available in the new home county; or
    - Change their county of coverage from home to work in order to keep their current carrier (providing that the current carrier is available in their work county).

- If employees have coverage in their **work** county and they move their residence to a county where their current carrier is not available, the employees will not be allowed to change carriers because their carrier is still available in their county of choice (work).

  Changes in coverage options during the Plan Year are not allowed.

- **Effective Date**

  First day of the month following the employee's signature date on the application.

  In Plan Year 2005, only one health insurance carrier is available per geographic region. Upon receipt of an address change request, the DEI will process the request and will notify the health insurance carrier of the required change in health insurance carriers. In some instances, address change notifications that require a carrier change are received by the DEI on an update form. The update form will be acceptable.

- **Deadline**

  Thirty (30) days from the event. However, if employees fail to notify the insurance coordinator of an address change that causes a move out of the service area, the Qualifying Event will be processed even if the thirty (30) day deadline is not met

- **Supporting Documentation Needed**

  None

2. Spouse Changes Primary Residence

- **What can employees do?**

  Drop spouse if spouse becomes ineligible for current benefit elections

- **Effective Date**

  Last day of the month in which the employee signs the Drop form

- **Deadline**

  Thirty (30) days from the Qualifying Event date

- **Supporting Documentation Needed**

  None

3. Dependent Child Changes Primary Residence

- **What can employees do?**

  Drop the ineligible dependent - *REQUIRED*

- **Effective Date**

  The ineligible dependent's coverage will end at the end of the month in which the dependent becomes ineligible (date of dependent's marriage, date of change in primary residence, attaining the limiting age, etc.)

- **Deadline**

  Thirty (30) days from the event date. This Qualifying Event makes the dependent ineligible to participate in the Public Employee Health Insurance Program; therefore, the ineligible dependent will be dropped from the plan at the end of the month of ineligibility even if the thirty (30) day deadline is not met

- **Supporting Documentation Needed**

  - In most cases – none
  - The DEI reserves the right to request supporting documentation. The insurance coordinator will be notified if supporting documentation is needed.

I. Other Events

1. Loss of Other Group Health Insurance Coverage

- **What can employees do?**

  Add themselves, spouse and dependents if the event entitles employee or family members to be enrolled under HIPAA

- **Effective Date**

  First day of the month following the employee's signature date on the application or Add form

  The application or Add form may be signed by the employee prior to the loss of coverage. *Revised March 2004* (supersedes information on the Qualifying Event chart).

- **Deadline**

  Thirty (30) days from the Qualifying Event date. The Qualifying Event date is the date the added members lose coverage under the group health plan

- **Supporting Documentation Needed**

  - HIPAA certificate of prior coverage; or
  - Letter typed on agency letterhead that identifies the date of coverage termination and the persons who were covered by the group policy

2. **Judgment, Decree or Administrative Order Relating to Health Coverage for the Child** (Natural children; stepchildren; adopted children; children placed for adoption; foster children; grandchildren and other children for whom legal guardianship has been awarded)

- **What can employees do?**

  - Add children to an existing plan if required by a court order;
  - add children to an existing plan if legal guardianship has been awarded;
  - add themselves if they have previously waived coverage and the order stipulates to add child to the employees' plan offered through the employer (upon receipt of an administrative order, the employer must enroll the child on the plan. The employees are responsible for premiums due); or
  - drop children if the order stipulates that coverage is to be provided by the other parent

- **Effective Date**

  - If adding a child at the employee's request, the effective date is the first day of the month following the employee's signature on the application or Add form
  - If adding a child and employee's consent to enroll the child is not needed (as in the case of a National Medical Support Notice directed to the employer), the effective date is the first day of the month following the date of the administrative order or notice
  - If dropping a child upon expiration of an order, the effective date is the last day of the month in which the child ceases to meet the eligibility requirements
  - If dropping a child upon receipt of a new order releasing the employee from providing coverage for the child, the effective date is the last day of the month in which the child ceases to meet the eligibility requirements

- **Deadline**

  - Thirty (30) days from the date the order or guardianship documents are signed by a judge
  - Upon receipt of an order directing the employer to enroll an employee's child in the plan, the enrollment will be processed even if the thirty (30) day deadline is not met

- **Supporting Documentation Needed**

  - Filed and dated court decree or guardianship document; or
  - Agency's administrative order; or
  - National Medical Support Notice

3. Employee, Spouse or Dependent Becomes Entitled to Medicare

- **What can employees do?**

  Drop coverage for them, their spouse and their dependents if they become eligible and enrolled in Medicare

- **Effective Date of Termination**

  Last day of the month in which the employee signs the Drop form

- **Deadline**

  Thirty (30) days from the date the employee, spouse or dependents become entitled to and enroll in Medicare

  The Drop form may be signed by the employee prior to the event date. *Revised March 2004* (supersedes information on the Qualifying Event chart).

- **Supporting Documentation Needed**

  - Initial eligibility letter from the Medicare Office or
  - Copy of the Medicare card

4. Employee, Spouse or Dependent Becomes Entitled to Medicaid

- **What can employees do?**

  Drop coverage for them, their spouse and their dependents if they become eligible and enrolled in Medicaid

- **Effective Date of Termination**

  Last day of the month in which the employee signs the Drop form

- **Deadline**

  Thirty (30) days from the date the employee, spouse or dependents become entitled to and enroll in Medicaid

- **Supporting Documentation Needed**

  - Initial eligibility letter from the Medicaid Office and
  - Copy of the Medicaid card

5. Employee, Spouse or Dependent Loses Entitlement to Medicare, Medicaid, KCHIP or any Governmental Group Health Insurance Coverage

- **What can employees do?**

  Add themselves, spouse and dependents that have lost coverage

- **Effective Date**

  Last day of the month in which the employee signs the Drop form

- **Deadline**

  Thirty (30) days from the date of loss of coverage

  The application or Add form may be signed by the employee prior to the event date. *Revised March 2004* (supersedes information on the Qualifying Event chart).

- **Supporting Documentation Needed**

  - HIPAA certificate of prior coverage; or
  - Termination letter from government agency under which previous coverage was held

J. Cost or Coverage Changes

1. Spouse has a Different Open Enrollment Period

- **What can employees do?**

  - Add themselves, spouse and dependents if spouse elected to drop coverage for them during his open enrollment period
  - Drop themselves, spouse and dependents if spouse elected to enroll them during his open enrollment period

- **Effective Date**

  The effective date to add or drop will be the same as the effective date of the spouse's Open Enrollment effective dates

  The application, add or Drop form may be signed by the employee prior to the event date. The event date is the last day of the spouse's Open Enrollment period

- **Deadline**

  Thirty (30) days from the Qualifying Event date

- **Supporting Documentation Needed**

  Employer letter that identifies the open enrollment period dates, the effective date of coverage or termination, and the persons who will be covered by the plan or drop from the plan, if applicable

2. Employee/Retiree Makes Elections during an Open Enrollment Period of Another Employer or a State Sponsored Retirement Plan

- **What can employees do?**

  - Add themselves, spouse and dependents if employee/retiree elected to drop coverage for them during his open enrollment period
  - Drop themselves, spouse and dependents if employee/retiree elected to enroll them during his open enrollment period

- **Effective Date**

  The effective date to add or drop will be entered to match the effective date of the spouse's open enrollment effective dates

  The application, add or Drop form may be signed by the employee prior to the event date. The event date is the last day of the spouse's open enrollment period

- **Deadline**

  Thirty (30) days from the Qualifying Event date

- **Supporting Documentation Needed**

  Employer letter that identifies the open enrollment period dates, the effective date of coverage or termination, and the persons who will be covered by the plan or drop from the plan, if applicable

3. Employee's Death

- **What can employees do?**

  Drop coverage for deceased policyholder and covered dependents

- **Effective Date**

  - If employee is enrolled in a Single plan – coverage ends on the date of death
  - If employee is enrolled in a plan with dependents (Parent Plus, Couple or Family) – coverage will end at the end of the month of the employee's date of death

- **Deadline**

  Thirty (30) days from the employee's date of death. Upon notification of the employee's date of death, the coverage termination will be processed even if the thirty (30) day deadline is not met

- **Supporting Documentation Needed**

  None

- **Other**

  - If the employee is enrolled in a Single plan and the employee's date of death is between the 1st and the 15th of the month, the employee's account will be refunded any premiums paid for the month of death
  - If the employee is enrolled in a Single plan and the employee's date of death is between the 16th and the end of the month, the employee's account will not be refunded any premiums paid for the month of death
  - If the employee is enrolled in a Parent Plus, Couple or Family plan, coverage for the dependents will continue through the end of the month of the employee's death. Therefore, the employee's account will not be refunded any premiums paid for the month of death.

Consolidated Omnibus Budget Reconciliation Act of 1986

I What is COBRA Continuation Coverage?

The Consolidated Omnibus Budget Reconciliation Act of 1986, or COBRA, provides that virtually all employers who sponsor group health plans must permit covered individuals, who lose coverage under that plan as a result of certain enumerated events, to elect to continue their coverage under the plan for a prescribed period of time on a self-pay basis. Individuals who are entitled to COBRA continuation coverage are known as Qualified Beneficiaries.

II Who is Eligible for COBRA Continuation Coverage?

In general, qualified beneficiaries include employees, their spouses, and dependent children who are covered under the plan the day before the Qualifying Event occurs. An amendment to the COBRA regulations made by HIPAA, permits children born to, or placed for adoption with, an employee during the period of COBRA continuation coverage to be considered a qualified beneficiary.

III How are Qualified Beneficiaries Notified of their Rights?

COBRA regulations provide that a group health plan is required to provide written notice of COBRA rights to each covered employee and his or her spouse, if any, when coverage under the plan first commences. The regulations require that group health plans furnish written notice of COBRA rights no later than 90 days after their coverage begins. This written notice may be referred to as either the Initial Notice or the General Notice.

The DEI provides this notice in this Administration Manual (Refer to Appendix B) and on the Personnel Cabinet's Web site. The General Notice is available in word format on the

web page to aid you in complying with the COBRA regulations. This notice should be sent to all covered employees and their spouses. The sending of other notices is dependent upon the occurrence of certain events.

IV What are COBRA Triggering Events?

A. The following are triggering events that an employee may experience:
- Termination of employment (for reasons other than the employee's gross misconduct) ; and
- Reduction in the employee's hours of employment.

B. The following are triggering events that an employee's spouse or dependent children may experience:
- Termination of employment (for reasons other than the employee's gross misconduct) ;
- Reduction in the employee's hours of employment;
- Death of the employee;
- Divorce or legal separation from the employee;
- The employee's entitlement to Medicare;
- The employer's commencement of a bankruptcy proceeding under Title 11 of the United States Code; and
- The child ceasing to be a covered dependent child under the terms of the Plan.

Anytime you are notified of a triggering event, you need to determine whether that event caused the member to lose group health coverage. If it does, then it is a Qualifying Event, and you will need to take further action to notify the qualified beneficiaries of their COBRA rights.

V. What is a COBRA Qualifying Event?

A COBRA Qualifying Event is one of the trigging events listed above that results in the loss of coverage for a qualified beneficiary. The COBRA regulations provide that a triggering event is a Qualifying Event only "if, under the terms of the group health plan, the event causes the covered employee, or the spouse or a dependent child of the covered employee, to lose coverage under the plan."

Therefore, when determining if a triggering event caused a loss of coverage, carefully review the facts and relevant documents. When was the loss of coverage? Examine the Qualifying Event chart to be certain that it provides a loss of coverage upon the occurrence of a particular triggering event.

VI. When a Qualifying Event Occurs: Who Must Notify Whom?

The employer cannot detect the occurrence of some Qualifying Events, because information concerning such events is uniquely within the control of the qualified beneficiary. If the event results in a loss of coverage under the group plan then the COBRA regulations require that the covered employee or other qualified beneficiary notify the insurance coordinator of the following events:
- Divorce or legal separation;

- A dependent child ceasing to qualify as a dependent under the terms of the plan;
- The occurrence of a second Qualifying Event after the qualified beneficiary becomes entitled to COBRA continuation coverage with the maximum duration of 18 or 29 months; and
- A determination by the Social Security Administration (SSA) that a covered employee or other qualified beneficiary is disabled, or a subsequent determination by the SSA that the individual is no longer disabled.

The employee or their qualified beneficiary is required to notify you no later than 60 days after the Qualifying Event. Failure to notify you in a timely manner will result in unavailability of COBRA continuation coverage for that individual.

The employer must notify the employee of some Qualifying Events. If the event results in a loss of coverage under the group health plan, then the employer must notify the covered employee and their spouse and dependent children for the following events:

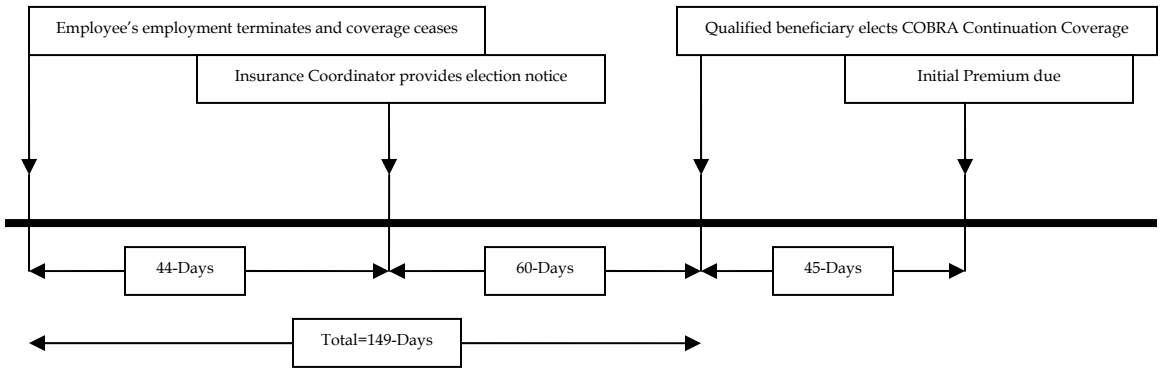
- Death of the covered employee;
- Termination of employment (other than for gross mis-conduct);
- Reduction in the employee's hours of employment;
- The employee's entitlement to Medicare (under Parts A or B, or both); and
- The employer's bankruptcy.

According to the COBRA regulations, you are required to send the election notice (Refer to Appendix C) to the employee and their qualified beneficiaries after notification of a Qualifying Event. You are required to send this notice no later than 44 days after the Qualifying Event or receiving notice from the employee or their qualified beneficiary that a Qualifying Event has occurred. You must provide an Election Notice to all qualified beneficiaries covered under the plan the day before the event occurred.

VII How Long is the Election Period?

A group health plan can require that qualified beneficiaries timely elect COBRA continuation coverage in order to receive such coverage. An election of COBRA continuation coverage will be considered timely if it is made during the election period.

The COBRA regulations provide that the election period must begin on or before the date that the qualified beneficiary would lose coverage as a result of a Qualifying Event. Further, the election period must remain open for 60 days from the later of the date coverage would be lost because of a Qualifying Event, or the date notice is provided to the qualified beneficiary of his or her right to elect COBRA continuation coverage.



VIII. After Receiving the Election Notice: What is Next?

After receiving the election notice, you should take the following steps:

- Review the election form and check to make sure it is completed correctly and all information is completed;
- Copy all documentation received from the qualified beneficiary;
- Forward copies of the election notice to the appropriate insurance carrier (the election notice should not be held until the initial premium payment is received); and
- If payment for COBRA continuation coverage is received later, forward to appropriate insurance carrier.

IX What Steps Should You Take if COBRA Continuation Coverage is Unavailable?

The COBRA regulations provide that, if a plan administrator receives notice from a covered employee or other qualified beneficiary of a Qualifying Event, second Qualifying Event or a request for disability extension, but the administrator determines that the individual is not entitled to COBRA continuation coverage, then the administrator must provide such an individual with a written explanation as to why he or she is not entitled to elect COBRA continuation coverage.

This notice is the Unavailability Notice and is required to be sent to the covered employee or other qualified beneficiaries no later than 14 days after receipt of the election notice. These notices along with all other notices are in this administration manual (refer to Appendix E) and available on the DEI Web site.

X. How Much Will COBRA Continuation Coverage Cost?

COBRA regulations do not require employers to pay for continuation coverage. Instead, employers are expressly permitted to charge employees 100 percent of the cost of the group health coverage, plus an additional 2 percent, for a total premium of 102 percent. The COBRA rates are included in this manual (refer to Appendix O) and the Personnel Cabinet's Web site. The additional two percent covers the added cost for administering COBRA continuation coverage.

XI. Is There a Grace Period for Premiums?

The COBRA regulations provides for two grace periods within which COBRA continuation coverage premiums must be paid. In general, the initial premium payment must be made within 45 days of the COBRA continuation coverage election, and all other premium payments must be made within 30 days after the first day of the coverage period to which they relate.

XII. How Should I Send the Notices?

The COBRA regulations state that, when furnishing required material, the plan administrator "shall use measures reasonably calculated to ensure actual receipt of the material" by intended recipients, and the regulation specifically mentions first class mail. The COBRA regulations only require you to show proof that the notice was sent in good faith and in a timely manner to the last known address of the qualified beneficiary.

The DEI strongly recommends that the notices be sent by certified mail without return receipt. This method will enable you to show proof that the notice was mailed to the last known address and the date which it was sent. If you are unable to send by this method, you should consider hand delivery. You should take precautions in delivery of the notices by this method. If hand delivering, make a check list and obtain the covered employees signature and date that he or she receive the notice from you. Proof of the date a notice was sent is crucial when defending a claim for failure to provide a timely COBRA notice.

XIII. What is the Length of the COBRA Continuation Coverage Period?

Listed below is the maximum period COBRA continuation coverage is available.

Qualifying Events that entitle you to COBRA continuation coverage	**Length of COBRA continuation coverage**
Termination of employee's employment (except for gross misconduct) (Former employee and covered dependents)	18 Months
Reduction of the employee's hours (Former employee and covered dependents)	18 Months
Death of a covered employee (Spouse and covered dependents)	36 Months
Divorce or legal separation from the covered employee (Spouse and covered dependents)	36 Months
Employee becomes entitled to Medicare (Part A, Part B or both) (Spouse and covered dependents)	36 Months
Dependent child covered under plan ceases to be an eligible dependent under the plan	36 Months
Person considered to have total disability, according to the Social Security Administration	29 Months

EMPLOYEE ORIENTATION

FOR A PRINTABLE VERSION OF ALL FORMS, PLEASE GO TO THE DEI'S WEBSITE AT:

http://personnel.ky.gov/hlthins/adminifo.htm.

I Employee Orientation

This Chapter has been designed to assist insurance coordinators with the enrollment of new employees. All new employees should receive the following information:

- Health Insurance Handbook and any supplements, if applicable;
- Health Insurance Application;
- Flexible Spending Account Handbook, if applicable;
- Flexible Spending Account Application, if applicable;
- General Notice of Right to Continuation of Group Health Insurance Coverage (refer to Appendix B);
- Memorandum regarding Notice about Special Enrollment Rights and Notice about Women's Health and Cancer Right Acts (this notice is required by Federal guidelines) (refer to Appendix F); AND
- Health Insurance Checklist (refer to Appendix G). New employees should be given this checklist for review and they should check each item as explained to them by the insurance coordinator. This checklist ensures that employees have received the required information and protects the insurance coordinator in the event of a discrepancy.

Copies of the COBRA memorandum, health insurance checklist and all applications should be maintained in the employee's personnel file.

II Health Insurance Checklist

A Health Insurance Checklist form is included in this Administration Manual (refer to Appendix G) to ensure consistency in the explanation of Health Insurance and Flexible Spending Account benefits.

- This form has been designed to cover essential health insurance information that MUST be given to the employee during the initial benefit orientation session.

- The completed Checklist, along with the appropriate copies of the health insurance application, Flexible Spending Account enrollment form, (if applicable) should be made a part of the employee's personnel file as an acknowledgement of receipt of information. A copy of all forms should be given to the employee once they have been completed.

- If your organization is already using a benefit orientation form, make sure you incorporate all topics included on this Checklist.

- On the last page of the Health Insurance Checklist, the employee must respond to the question regarding previous employment within the last sixty-three (63) days with another agency participating in the Public Employee Health Insurance Program.

    - If the employee's break in service is greater than sixty-three (63) days, then the employee can make any elections (treat as a new employee).

    - If the employee's break in service is sixty-three (63) days or less, the employee cannot change his/her previous elections unless he/she experienced a Qualifying Event giving rise to a permitted mid-year election change.

NOTE: The DEI is not attempting to alter your agency's policies pertaining to effective dates and payroll issues. You may consider an employee to be a "new employee" instead of a "transferring employee", but the employee will not be permitted to make election changes without a sixty-three (63) day break in service.

III Memorandum regarding Notice about Special Enrollment Rights and Notice about Women's Health and Cancer Rights Act

Federal law requires that every employee must receive notification of the Notice of Special Enrollment Rights and Notice about Women's Health and Cancer Rights Act. A copy of this notice is provide for your assistance (refer to Appendix F).

LEAVE

I. Leave Without Pay (LWOP)

A. Starting LWOP

If employees are on leave without pay and they receive pay during the month the leave starts, they will be eligible for the employer contribution for health insurance for the following month. However, if the pay the employee receives is not sufficient to cover the employee's portion of the premium, they must submit a check for the amount due.

If employees are on leave without pay and they do not receive pay during a month, they will not be eligible for the employer contribution for health insurance for the following month. In this case, the employees must pay the total premium amount (employer and employee portion, if applicable) to continue their health insurance coverage.

Any portion of a premium due by the employee must be submitted to the insurance coordinator by the 20th of the month.

The check must be payable to the appropriate health insurance carrier.

The insurance coordinator will forward the payment to the appropriate health insurance carrier.

NOTE: If the employee fails to submit appropriate premium payments due within the specified deadline, the health insurance carrier may cancel the ENTIRE POLICY. If this occurs, the insurance coordinator should request a refund of any employer contribution amount paid.

NOTE: When employees are granted FMLA leave, the insurance coordinator should send the "Guidelines for Benefits While on Approved LWOP" memo (refer to Appendix H).

B. Thirty (30) or more working days

The insurance coordinator must submit an Update form to the DEI providing the employee's LWOP begin date and the health insurance coverage termination date.

If the LWOP employee has selected the cross-reference payment option, the cross-reference payment option must be broken. The DEI will notify the spouse's insurance coordinator that one of the cross-reference employees is on LWOP and will be changed to a Family non-cross-reference plan providing that the employee on LWOP does not elect COBRA continuation coverage. If the employee on

LWOP does not elect COBRA continuation coverage, the remaining employee will be responsible for payment of the total employee contribution for the family plan.

The insurance coordinator must notify employees on LWOP of their COBRA rights.

C. During LWOP

While employees are on LWOP, the following could occur:

1. There is an Open Enrollment Period

Employees that are on LWOP during the Open Enrollment Period will not receive an Open Enrollment packet.

Employees that elected COBRA will receive Open Enrollment packets from their health insurance carrier.

Upon returning to work, the employee is entitled to receive the Open Enrollment information from the insurance coordinator. Employees will have thirty (30) days from the date they return to work to apply for their Open Enrollment selections.

2. The employees experience a Qualifying Event

Employees on LWOP that experience a Qualifying Event must follow the same status change rules. They must request the mid-year election change within the required time limits for such requests (thirty (30) days from the event, except for adding a newborn (only), which is sixty (60) days).

The insurance coordinator will keep the Qualifying Event application on file until the employee returns to work. At that time, the employee's application will be sent to the DEI for processing.

The same rules as defined in the "Returning from LWOP" section will be applied to determine the effective date of coverage.

D. Returning from LWOP

1. Eligibility for Employer Contribution

Any employee who returns to work after being on LWOP must work at least one day in the month they return to be eligible to receive the employer contribution for health insurance for the following month.

If the employee does not work one day or more in the month they return, the first day of the second month rule applies.

2. Eligibility for Coverage Changes

Employees who return to work after being on LWOP will not be eligible to make any changes to their health insurance coverage unless:

- They have experienced a Qualifying Event and they apply for an appropriate change following the Qualifying Events.
- They return in a new Plan Year and they were on LWOP during the Open Enrollment Period. Employees must apply for a coverage change no later than thirty (30) days after their return.

The insurance coordinator must provide the necessary applications upon return.

II Family Medical Leave Act (FMLA)

The Family and Medical Leave Act of 1993 (FMLA) requires employers to provide up to twelve (12) weeks of job-protected leave for certain family and medical reasons. Employees are eligible for FMLA leave if they have completed twelve (12) months of service and worked or been on paid leave at least 1,250 hours in the twelve (12) months preceding the first day of FMLA leave. This leave is available annually.

The employee may choose to use paid (annual, sick or compensatory) leave concurrently with FMLA leave. [101 KAR 2:102] The employee may choose to use unpaid leave during the FMLA leave. The employee may choose to reserve ten (10) days of accumulated sick leave prior to being placed on FMLA leave.

NOTE: When the employee is granted FMLA leave, the insurance coordinator should send the "Guidelines for Benefits While on Approved Family Leave" memo (refer to Appendix I).

A. Starting FMLA Leave

- FMLA Leave is not a Qualifying Event to change health insurance elections.
- When employees begin FMLA leave, the employer contribution for health insurance is to continue through the leave period.
- Employees are responsible for the employee's share of the health insurance premiums. Employees may choose to:
  - Cease contributions (terminates entire policy);
  - Prepay the coverage contributions for the FMLA leave period;
  - Choose the pay-as-you-go method. If employees choose this method of payment:
    - The employee's contribution is due at the same time the contribution would be due if made by payroll deduction;
    - If employees fail to pay timely, they will be granted a thirty (30) day grace period;
    - If employees fail to pay the required amount by the end of the thirty(30) day grace period, the policy will be

automatically terminated back to the last date through which premium was paid; or

- Choose the catch-up option, which should be agreed to by both parties **PRIOR** to the FMLA leave.

- The insurance coordinator is to collect the premium check (made payable to the insurance carrier) and forward it to the carrier. The insurance coordinator is to collect and process all premium checks while the employee is on FMLA leave.

B. During FMLA

While employees are on FMLA, the following could occur:

1. There is an Open Enrollment Period

Employees that are on FMLA during Open Enrollment, will receive an Open Enrollment packet from the insurance coordinator.

Employees that choose to cease contributions are not eligible for health insurance under the Public Employee Health Insurance Program until they return to work.

2. Employee experiences a Qualifying Event

Employees on FMLA that experience a Qualifying Even must follow the same status change rules. They must request the mid-year election change within the required time limits for such requests (thirty (30) days from the event, except for adding a newborn (only), which is sixty (60) days).

The insurance coordinator will keep the Qualifying Event application on file until the employee returns to work. At that time, the employee's application will be sent to the DEI for processing.

The same rules as defined in the "Returning from FMLA section" will be applied to determine the effective date of coverage.

3. Returning from FMLA Leave

- Employees returning from FMLA leave must be reinstated to the prior elections unless there has been an intervening status change Qualifying Event (birth, adoption, etc.), in which case, the employees are held to the same thirty (30) day rule for requesting the coverage change.
- If the employee chose to suspend health insurance coverage during the FMLA leave, the employee is to be reinstated to the prior elections.
- If the employee had coverage cancelled due to non-payment of premiums, the employee is to be reinstated to the prior elections upon payment of all past-due premiums.

- If the employee chose suspension of coverage or fails to pay past-due premiums, the agency is to request a refund of the employer contribution for the applicable months.

4. Not returning from FMLA Leave

When an employee has exhausted FMLA leave, but does not return to work (begins LWOP), the insurance coordinator must notify the employee of their COBRA rights, regardless of the employee's insurance status during the FMLA leave.

For purposes of COBRA, the date of this COBRA Qualifying Event is the date the FMLA leave ends. The employee is eligible for eighteen (18) months of COBRA coverage.

III Paid Leave

An employee who has worked or been on paid leave (annual, sick or compensatory time) for at least one day during a month will be eligible for the state contribution for health benefits for the following month. Paid leave must be used consecutively.

IV Military Leave

Employees called to active military duty are eligible for health benefits through the United States Government. The employee's dependents may also be eligible for military health insurance.

1. Starting Military Leave

Employees may "stop" their health insurance coverage on the last day of the month in which they are activated with the armed services.

Employees may elect to maintain their current level of health insurance coverage as well as maintain military health care coverage.

NOTE: Refer to the Qualifying Event Chart regarding Flexible Spending Accounts during Military Leave (State Agencies only).

If an employee has single coverage through the Public Employee Health Insurance Program and is using paid leave or has not been removed from the payroll via formal action:

- Employees may "Stop" their health insurance coverage on the last day of the month in which they are activated with the armed services. This option will allow employees to "Start" their health insurance coverage immediately upon return to public employment. This "Stop" and "Start" process will in no way negatively impact employees with regard to pre-existing conditions.

- If employees elect to maintain their current level of health insurance coverage, as well as maintain military health care coverage, employees must insure that the applicable premiums are available via payroll deduction or

are received by their insurance coordinator no later than the 20th day of the month preceding the coverage month.

If an employee has coverage for dependents through the Public Employee Health Insurance Program:

- an employee may elect to maintain their current level of health insurance coverage and insure that the applicable premiums are available via payroll deduction or are received by their insurance coordinator no later than the 20th day of the month preceding the coverage month.

- Employees may "Stop" their health insurance coverage on the last day of the month in which they are activated with the armed services. This option will allow employees to "Start" their health insurance upon return to public employment. This Stop and Start process will in no way negatively impact employees with regard to pre-existing conditions application to claims for service under the DEI policy.

An employee called to active duty must elect one of the preceding options for their health insurance during the time they are activated. The only option that may be affected by the minimum or maximum length of activation is dependent coverage and the employee is responsible for that verification. All premiums due upon return from active duty will be determined by the date of return to active employment.

2. During Military Leave

If employees elect to maintain their health insurance while on leave, they must ensure that the applicable premiums are available via payroll deduction or are received by their insurance coordinator no later than the 20th day of the month preceding the coverage month.

3. Returning from Military Leave

Employees returning from Military Leave will have all benefits (Health Insurance and Flexible Spending Accounts) reinstated upon their return, effective the date they return, (first day of the second month rule does not apply) without any waiting period for pre-existing conditions.

NOTE: Employees returning from Military Leave may delay the effective date until military coverage ends (at the employee's option). Employees electing this option will have to present supporting documentation of the military coverage end date.

An employee returning between the first (1st) and the fifteenth (15th) of the month will need to pay the employee portion (family, couple, parent plus or single, if applicable) of the insurance premium for the month of return. An employee returning on the sixteenth (16th) of the month or later will be exempt from paying the premium for the month of return. In both cases, the employee will pay the premium for subsequent months.

REPORTS

Throughout the year, the Department for Employee Insurance will generate reports to the insurance coordinators. These reports are developed within the Group Health Insurance (GHI) database and are provided to update insurance coordinators on applications processed through this database system. A description of each report and detailed information regarding what you are to do with each report are provided below.

I. TEFRA - For Active State Employees Age Sixty-five (65) and Older

Every month, the Personnel Cabinet's Payroll Branch will generate a report of all active state employees who will turn age sixty-five (65) in the next three (3) months. DEI's Member Services Branch will distribute this report to appropriate insurance coordinators. The TEFRA letter in Appendix A should be mailed to the employees on that list. The letter details how TEFRA affects the employee and what their options are at age sixty-five (65).

II GHI Automatic Emails

The Group Health Insurance system automatically generates an email notification to the insurance coordinator when an action is taken on a member's record. Actions such as Accepts, Terminations, Rejects or Pends will generate an email to the insurance coordinator of record. If you have submitted transactions to the EIB and have not received automatic emails, notify the EIB immediately.

III Pended Records

This report is generated **weekly** and is mailed to each agency's health insurance coordinator. If an employee's application has been pended for any reason, you will receive a report listing the employee's social security number, name, middle initial, the date it was pended and a note written by the EIB processor providing details about the "Pend" action. The report also contains a message indicating the time the record has been in "Pended" status and the action that will be taken if the issue is not resolved within the deadline. Pended records must be resolved within sixty (60) days of the original "Pend" date. Records in "Pend" status for a period greater than sixty (60) days will be rejected. This will be done automatically and documentation received after the deadline will not be accepted. If an application has been rejected, you will be notified, in writing, by the EIB.

Please be aware that the deadlines for Qualifying Events have not changed. Most Qualifying Events must be signed within thirty (30) days after the event date. If a Qualifying Event

form has been signed within the deadlines, but it has been pended for supporting documentation or other reason, the member will have up to sixty (60) days from the original "Pend" date to submit the proper documentation or information requested.

IV Ineligible Dependents (Age 24)

This report is generated monthly and is mailed to each agency's health insurance coordinator. This report includes information for any dependent in your agency that will turn twenty-four (24) during the following month. As indicated on the report, the DEI will make changes to the employees health insurance based on the type of coverage they currently have and if other dependents continue to be covered under the plan. This report is provided as a tool for you to notify employees that have dependents no longer eligible for the program. This also is a tool to assist you in offering COBRA benefits to dependents no longer eligible for the group plan. Remember, a dependent dropped due to obtaining the limiting age must be offered COBRA and must be notified of COBRA eligibility.

If an employee has other eligible children covered under the plan, coverage will remain the same. If the child to be dropped is the only dependent child on the employee's plan, the plan holder will be assigned a plan as follows:

A. a Parent Plus plan will be assigned to a Single Plan.
B. a Family plan will be assigned to a Couple Plan.
C. a Family paying by cross-reference will be assigned to two Single Plans.

V Enrollment Confirmation

This is a quarterly report that lists all employees of an agency that have elected coverage or that have waived coverage.

The information on this report is current as of the report run date and is ordered by last name. Due to the size of the report, it is also available in electronic format, upon request. If you would prefer not to receive this report, you may notify the EIB.

VI Open Enrollment Confirmation Report

This report is generated weekly during the Open Enrollment Period. It includes all open enrollment records for your agency processed by the DEI for the prior week. The report is ordered alphabetically and it includes your employees' name, Social Security Number, health plan selections and Flexible Spending Account information, if applicable.

Commonwealth Choice Flexible Spending Accounts

I. Commonwealth Choice Plan Administrator

Fringe Benefits Management Company
P. O. Box 1878
Tallahassee, Florida 32302-1878

Customer Service: (800) 342-8017
(800) 955-8771 (TDD)
(850) 425-4608 (FAX)
www.fbmc-benefits.com

Interactive Benefits Information Line – (800) 865-3262

II Reimbursement Requests

Employees should mail or fax all requests for reimbursement of expenses incurred to:

Fringe Benefits Management Company
P. O. Box 1800
Tallahassee, Florida 32302-1800
Fax: (850) 425-4608

III. Questions Regarding Eligibility

An employee having questions regarding eligibility for the Commonwealth Choice Flexible Spending Accounts should contact:

Personnel Cabinet
Department for Employee Insurance
Commonwealth Choice Administrator
Member Services Branch
(888) 581-8834
(502) 564-0351 or (502) 564-0350

IV Commonwealth Choice Flexible Spending Accounts

The Commonwealth Choice Flexible Spending Account (FSA) program allows participating Commonwealth of Kentucky employees to pay for eligible Dependent Care expenses and eligible Medical Expenses with pre-tax dollars.

V Eligibility Requirements

An active state government employee who is eligible for state-sponsored health insurance coverage may enroll in one or both of the Medical and Dependent Spending Accounts during Open Enrollment or as a result of an applicable Qualifying Event. Refer to the Qualifying Event chart for applicable events that would allow enrollment into the Flexible Spending Account program other than during Open Enrollment

An employee may enroll in the Commonwealth Choice program within thirty (30) days of his employment date or thirty (30) days of his eligibility for benefits date. The effective date will be the first day of the second month from date of hire (i.e. employee hire date is 2/25, employee's effective date would be 4/1). Indicate the effective date on the enrollment application and adjust the number of pay periods accordingly by using the chart below:

VI UPPS Payroll Guidelines for Commonwealth Choice Deductions

Hire Date	Effective Date	# of Pay Periods Remaining in PY	First Pay Period Deductions Will be Made
November	January	24	01/15 – 01/31
December	February	22	02/15 – 02/28
January	March	20	03/15 – 03/31
February	April	18	04/15 – 04/30
March	May	16	05/15 – 05/31
April	June	14	06/15 – 06/30
May	July	12	07/15 – 07/31
June	August	10	08/15 – 08/31
July	September	8	09/15 – 09/30
August	October	6	10/15 – 10/31
September	November	4	11/15 – 11/30
October	December	2	12/15 – 12/31

An employee, who previously worked for state government and had less than a sixty-three (63) day break in service, and returns to employment, will have the same elections prior to their break in service, unless there is an intervening status change that may result in new elections.

An employee who previously worked for state government and had a break in service of sixty-three (60) day or greater, and returns to employment, should be treated as a new employee.

An employee, who signs up for Commonwealth Choice during Open Enrollment **and terminates employment before coverage is effective on January 1st,** will not be offered COBRA coverage under the Flexible Spending Account for the upcoming plan year, but offered COBRA coverage for the prior year the employee terminated. If the employee returns to work after the plan year begins with less than a sixty-three (63) day break, he will have the same elections that he had chosen during his open enrollment period. An employee with a sixty-three (63) day break or greater in service will be eligible to enroll as a new employee, with an effective date of the first day of the second month after the date of employment.

VII Open Enrollment

Eligible employees who wish to participate in either or both the Medical Expense Flexible Spending Account and the Dependent Care Account must complete a new enrollment form each year during the open enrollment period. Participation is NOT automatic.

VIII Payroll Processing

A. Open Enrollment

Payroll deductions will be downloaded from the DEI's database. Do NOT set up deductions during the Open Enrollment Period unless instructed by the DEI. The DEI will send Open Enrollment information electronically to the Commonwealth Choice vendor.

B. Initial Enrollment (New Hire) and Special Enrollment (Change in Status/Qualifying Events)

For information on enrollment outside Open Enrollment (i.e. new hires and change in status), contact your payroll officer or the DEI. Payroll deductions for initial enrollment will be set up by the DEI and payroll deductions for special enrollment must be set up by the insurance coordinator.

IX Change in Status/Qualifying Events

Refer to the Qualifying Event Chart.

X Contribution Amounts

The combined contribution amount from the employer and employee per pay period for either the Medical Expense FSA or the Dependent Care account is $5.00 minimum and $120 maximum.

The maximum yearly contribution amount for Dependent Care depends on your tax filing status as listed below:

- married filing separately - $2,500
- single and head of household - $5,000
- married and filing jointly - $5,000

Employees may qualify for the defined employer contribution amount of $234 if the employee waives health insurance coverage with the Public Employee Health Insurance Program.

NOTE: The amount that an employee may receive toward a Medical Expense Flexible Spending Account is the defined employer contribution amount of $234.

Employer contributions cannot be directed into the Dependent Care Account.

XI Leave without Pay (LWOP)

A. Thirty (30) days or less

Employees on LWOP that do not have pay during a pay period, will not be eligible for the employer contribution for medical expense flexible spending account for that pay period. It will be the employee's responsibility to pay the combined contribution (employer/employee) for that pay period.

The employee should submit a check made payable to the **Kentucky State Treasurer** by the **30th** of the month to:

Personnel Cabinet
Department for Employee Insurance
Commonwealth Choice Administrator
Member Service Branch
5th Floor – Suite 502
200 Fair Oaks Lane
Frankfort, Kentucky 40601

NOTE: **If employees fail to submit a check by the due date, the total combined contribution (employee/employer) should be deducted from the first paycheck they receive once they return from LWOP. If the employee's contribution is an amount greater than anticipated by the employee, consult with the employee to determine the preferred method of payment to make current.**

B. Greater than thirty (30) day break in service

If an employee is on leave for more than thirty (30) working days the insurance coordinator should do the following:

- Submit an Update form to the DEI providing the employee's LWOP beginning date and the FSA termination date (term date for FSA is the same as the LWOP beginning date).
- Notify the employee about COBRA rights.

XII Open Enrollment Period

If an employee is on LWOP during Open Enrollment, the insurance coordinator does not need to send an open enrollment packet. The packet is to be given upon the employee's return from LWOP.

If the employee did not elect COBRA, he is not eligible for the medical expense flexible spending account through the Public Employee Health Insurance Program until he returns to work.

If the employee elected COBRA, the Commonwealth Choice COBRA Administrator will send Open Enrollment information to the employee.

XIII Qualifying Event

If an employee on LWOP experiences a Qualifying Event, the same status change rules apply. The employee must request the mid-year election change within the required time limits. Refer to the Qualifying Event Chart.

NOTE: An employee is not eligible to file for reimbursement of Dependent Care expenses incurred while on LWOP.

XIV Returning From LWOP

Employees returning from LWOP should be reinstated to the same elections prior to LWOP unless they experience a Qualifying Event and made changes within the required time limit for the event.

Reinstatement of an employee's prior election can be accomplished with one of the following methods (employee's choice):

Proration: Employee may elect to continue at the same monthly contribution amount prior to the LWOP termination date and the annual amount is reduced by the contributions missed.

Or

Reinstatement: Employee may elect to make-up the missed contributions.

XV Eligibility for Employer Contribution for Medical Expense FSA

An employee who returns to work after being on LWOP must work at least one day in the month he returns to be eligible to receive the employer contribution for the medical expense flexible spending account in the following month.

XVI Medical Expense Flexible Spending Account Changes

Employees who return to work after being on LWOP will not be eligible to make any changes to the medical expense FSA in which they were enrolled prior to the LWOP unless one of the following has occurred:

- The employee experiences a Qualifying Event and applies for an appropriate change within the required time limit.
- The employee returns in a new plan year or after the open enrollment period and applies for a coverage change no later than thirty (30) days after his return date.

NOTE: Sixty-three (63) day rule still applies.

XVII Family Medical Leave Act (FMLA)

When the employee is granted FMLA leave, the insurance coordinator should send the "Employee on FMLA Leave Memo".

A. Beginning FMLA Leave

FMLA leave is not a Qualifying Event to make any changes to the medical expense flexible spending account.

When an employee begins FMLA leave, the employer contribution for the medical flexible spending account is to continue through the leave period.

The employee is responsible for the employee's share (if any) of the medical flexible spending account. The employee may choose to:

- Cease contributions (terminate the entire contribution);
- Prepay the total contribution for the FMLA leave period (employee's contribution);
- Choose the pay-as-you-go method. If the employee chooses this method of payment, the employee's contribution is due at the same time the contribution would be made by payroll deduction. Employees who fail to pay timely will be granted a thirty (30) day grace period to pay the contributions. Employees who fail to pay the required amount by the end of the thirty (30) day grace period, will have the medical expense flexible spending account automatically terminated back to the last date through which contributions were paid. The employee will not be able to participate the remainder of the year.

When the employee is on FMLA leave, forward contribution checks to:

Personnel Cabinet
Department for Employee Insurance
Commonwealth Choice Administrator
Member Services Branch
200 Fair Oaks, Suite 501
Frankfort, Kentucky 40601

B. Returning from FMLA Leave

Upon the employee's return from FMLA leave, the employee must be reinstated to the prior elections before FMLA leave unless there has been a status change (birth, adoption, etc), in which case, the employee is held to the same thirty (30) day rule for requesting the change.

The employee may choose one of the following:

Proration: Employee may elect to continue the same monthly contribution as prior to the FMLA leave and the annual amount is reduced by the contributions missed.

or

Reinstatement: Employee may elect to make-up the missed contributions.

NOTE: If employees choose suspension of their medical expense flexible spending account or fail to pay the past-due contributions, the agency is to request a refund of the employer contribution for the applicable pay period.

C. Not returning from FMLA Leave

When employees have exhausted their FMLA leave, and do not return to work (begins LWOP), the insurance coordinator must notify the employee of their COBRA rights, regardless of the employee's medical expense flexible spending account status during the FMLA.

For purposes of COBRA, the date of the COBRA Qualifying Event is the date the FMLA leave ends. The employee is eligible for eighteen (18) months of COBRA.

XVIII Military Leave

Employees may discontinue their contributions to the Commonwealth Choice Program when they are activated with the armed services. This option will allow the employee to be reinstated when returning to employment from military leave. The employee may select one of the following upon return:

Proration: Employee may elect to continue at the same monthly contribution prior to military leave and the annual amount is reduced by the contributions missed.

or

Reinstatement: Employee may elect to makeup the missed contributions.

Employees returning between the first (1st) and the fifteenth (15th) of the month will need to pay the entire employee's contribution and the Agency will be required to pay the employer's portion of the contribution, if any, for the medical expense flexible spending account for the month the employee returns.

Employees returning on or after the 16th of the month will only need to pay half of their contribution and the Agency will be required to pay the employer's portion of the contribution, if any, for the month returned.

XIX HIPAA

Employees, as well as their eligible dependents, enrolled in the Medical Expense Flexible Spending Account must be provided with a written certificate of prior creditable coverage, in accordance with the Health Insurance Portability and Accountability Act (HIPAA), if they terminate employment or retire while actively participating in the program. The HIPAA certificate must be furnished even if all or part of the contribution was from the employer. A copy of the HIPAA certificate will be provided to employees and eligible dependents, from the carrier, upon leaving employment.

Glossary of Terms

Border County – An out-of-state county that is contiguous with the boundaries of the Commonwealth of Kentucky.

Carrier – A health maintenance organization, insurer or other entity, which has been issued a certificate of authority by the Department of Insurance.

Change in Status – Any event that changes the following:

(a) legal marital status (marriage, death of spouse, divorce, legal separation or annulment);
(b) number of dependents of qualifying individuals (for Dependent Care Assistance only), (birth, adoption, placement for adoption, or death of a dependent child);
(c) employment status (commencement or termination of work; strike or lockout; commencement or return from an unpaid leave of absence; or any benefit eligibility condition that depends on employment status, whereby an employment status change would result in an individual either becoming, or ceasing to be, eligible under a plan for Employee, Spouse or Dependent);
(d) dependent status (employee's dependent child satisfies, or ceases to satisfy, coverage requirements due to attainment of age, student status or any similar circumstances);
(e) residence or work site (change in Employee's, Spouse's or Dependent's place of residence or employment); and
(f) such other events as may be permitted by law or regulation.

COBRA – The Consolidated Omnibus Budget Reconciliation Acts of 1986, as amended, including parallel provisions as outlined in Title XXII of the Public Health Service Act. COBRA allows an employee to continue their group health insurance coverage for a period of time.

Contract Year – The year commencing on January 1 and ending on December 31 of each year. For the purposes of this Administration Manual, the terms "contract year" and plan year" are interchangeable.

Couple Coverage – Coverage for the member and their eligible covered spouse.

Coverage Level – Single, parent plus, couple or family coverage.

Creditable Coverage - Prior coverage by a covered person under any of the following:
(A) a group health plan, including church and governmental plans;
(B) health insurance coverage;
(C) Part A or Part B of Title XVIII of the Social Security Act (Medicare);
(D) Medicaid, other than coverage consisting solely of benefits under section 1928 of the Social Security Act;
(E) the health plan for active and certain former military personnel, including CHAMPUS and TRICARE;
(F) the Indian Health Service or other tribal organization program;
(G) a state health benefits risk pool;
(H) the Federal Employees Health Benefits Program;
(I) a public health plan as defined in federal regulations**;**
(J) a health benefit plan under section 5(e) of the Peace Corps Act; and any other plan which provides comprehensive hospital, medical, and surgical services and meets federal requirements.

Creditable coverage does not include any of the following:

- accident only coverage, disability income insurance, or any combination thereof;
- supplemental coverage to liability insurance;
- liability insurance, including general liability insurance and automobile liability insurance;
- workers' compensation or similar insurance;
- automobile medical payment insurance;
- credit-only insurance;
- coverage for on-site medical clinics;
- benefits if offered separately:
  (1) limited scope dental and vision;
  (2) long-term care, nursing home care, home health care, community based care, or any combination thereof; and
  (3) other similar, limited benefits.
- benefits if offered as independent, non-coordinated benefits:
  (1) specified disease or illness coverage; and
  (2) hospital indemnity or other fixed indemnity insurance.
- benefits if offered as a separate policy:
  (1) Medicare Supplement insurance;
  (2) supplemental coverage to the health plan for active and certain former military personnel, including CHAMPUS and TRICARE; and
  (3) similar supplemental coverage provided to group health plan coverage.

Cross Reference – A husband and wife who, as eligible employees of the Public Employee Health Insurance Program, may elect to have both state paid contributions applied to their family coverage.

Dual Employment – any employee who works full-time for different agencies (i.e. school board and state agency) and meets the eligibility requirement for both employers.

Effective Date – The date on which coverage for a covered person begins.

Eligible Person – A person who meets the eligibility requirements of the Public Employee Health Insurance Program.

Employee – A person who is employed by agencies of the Public Employee Health Insurance Program and eligible to apply for coverage under a Public Employee Health Insurance Program.

Enrollment Date – The first day of coverage of a member and their eligible dependents under the certificate, or if this is a waiting period, the first day of the waiting period (typically the date employment begins).

Family Coverage – Coverage for the member, the member's spouse under a legally valid existing marriage and one or more dependent children.

Late Enrollee – An eligible person who requests enrollment in a plan after the initial open enrollment period. An individual shall not be considered a late enrollee if:

(a) The person enrolls during their initial enrollment period;
(b) The person enrolls during any annual open enrollment period; or
(c) The person enrolls during a special enrollment period.

Member – An employee, retiree or COBRA participant who is covered by one of the health plans offered by the Public Employee Health Insurance Program.

Neighboring County – A county or counties that adjoin or are next to a border of the Commonwealth of Kentucky.

Open Enrollment – a defined period of time, prior to the beginning of a Coverage Period during which an employee shall be entitled to elect benefit options for the subsequent coverage period.

Parent Plus – Coverage for the member and eligible dependents, except the spouse.

Plan Year – Each successive twelve-month period starting on January 1 and ending on December 31.

Premium – The periodic charges due which the member, or the member's group, must pay to maintain coverage.

Premium Due Date – The date on which a premium is due to maintain coverage under the Public Employee Health Insurance Program.

Public Employee Health Insurance Program – The group, which is composed of eligible employees of state agencies, boards of education, local health departments, quasi agencies, retirees of KCTCS, retirees of the Kentucky Retirement Systems, Teachers' Retirement System, the Legislators Retirement Plan and the Judicial Retirement Plan who are under age 65, and their eligible dependents.

Qualified Beneficiary – Any individual who, on the day before a COBRA Qualifying Event, is covered under the plan by virtue of being on that day a covered person, or any child who is born or placed for adoption with a member during a period of COBRA continuation coverage.

Qualifying Event – A specific situation or occurrence that enables an eligible person to enroll or disenroll outside the designated enrollment period as a result of that person becoming eligible for or losing eligibility for coverage under this plan or another plan.

Retiree – A member of a retirement plan administered by the Kentucky Retirement Systems, Kentucky Teachers' Retirement System, Kentucky Legislators Retirement Plan, Kentucky Judicial Retirement Plan or any other state retirement system, who is under age 65.

Single Coverage – Coverage for the member only.

Special Enrollment Period – A period of time during which an eligible person or dependent who loses other health insurance coverage or incurs a change in status may enroll in the plan without being considered a late enrollee.

SAMPLE
USE YOUR AGENCY LETTERHEAD

M E M O R A N D U M

TO: *(Employee)*

FROM: Insurance Coordinator

DATE:

SUBJECT: TEFRA for Active Employees Age 65 and Over

This letter is to inform an employee, nearing the age of 65, of his/her health insurance options upon becoming eligible for Medicare. As a result of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Medicare now supplements employer group health insurance plans. This means that if an employee elects coverage under the state sponsored health insurance plan, Medicare will pay benefits on a secondary basis.

MEDICARE

You will receive information regarding Medicare enrollment approximately three months prior to your 65th birthday. *If you are eligible* for Medicare Part A, the coverage will be free and enrollment will be automatic. Medicare Part B is **not** free and enrollment is **not** automatic. You are encouraged to contact your local Social Security office to determine your eligibility for these programs.

PUBLIC EMPLOYEE HEALTH INSURANCE PROGRAM

Your Medicare eligibility or enrollment (Part A & Part B) does not affect your eligibility to continue coverage with the Public Employee Health Insurance Program as long as you continue to meet the eligibility requirements as an "employee". State sponsored plans offer the same health care coverage (under like conditions) to all active employees, regardless of age.

EMPLOYEE OPTIONS

Since you will be eligible to participate in Medicare and the Public Employees Health Insurance Program, you should compare the cost of each, the benefits of each and make your decisions based upon your needs.

You may choose Medicare Parts A & B as your only source of coverage and waive your state sponsored health insurance. There is a monthly premium for Medicare Part B. Some of the items not covered by Medicare at the present time include prescription drugs, eyeglasses, dentures, hearing aids, routine physical checkups and related tests.

You may choose not to enroll in Medicare Part B and continue in the state sponsored health insurance plan. The health insurance carrier will coordinate benefits with Medicare. You may delay enrollment in Medicare Part B until a later date, however, you will need to contact your local Social Security office regarding the Special Enrollment requirements, including dates.

Please contact your local Social Security office and/or check the Centers for Medicare and Medicaid Services website* to obtain all the information necessary to make your decisions.

*http://cms.hhs.gov/default.asp?fromhcfadotgov=true

Date of Notice

Name of Qualified Beneficiary
Address
City, State Zip

RE: **General Notice of Right to Continuation of Group Health Insurance Coverage**

Dear *List all Qualified Beneficiaries*:

You are receiving this notice because you have become covered under a group health plan (the Plan). This notice contains vital information regarding you and your dependents' rights for continuation of group health insurance. This notice was designed to give you a summary of COBRA and what rights you and your dependents have upon your loss of group health coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should contact the insurance coordinator at your agency of employment.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "Qualifying Event". Specific Qualifying Events are listed later in this notice. After a Qualifying Event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, qualified beneficiaries are responsible for payment of COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose coverage under the Plan because either one of the following Qualifying Events occurs:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following Qualifying Events occur:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare (Part A, Part B or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following Qualifying Events occur:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than gross misconduct;

- The parent-employee becomes enrolled in Medicare (Part A, Part B or both);
- The parents becomes divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child".

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the insurance coordinator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the end of employment or a reduction of hours of employment, death of the employee or the employee becoming entitled to Medicare benefits (under part A, Part B or both), the employer must notify the insurance coordinator of the Qualifying Event.

You must Give Notice of Some Qualifying Events

For other Qualifying Events (divorce, legal separation of the employee and the spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Department for Employee Insurance within sixty (60) days after the Qualifying Event occurs. You must provide this to your insurance coordinator at place of employment.

Length of COBRA Coverage Period

Listed below is the maximum period COBRA continuation coverage is available.

Qualifying Events that entitle you to COBRA continuation coverage	Length of COBRA continuation coverage
Termination of employee's employment (except for gross misconduct) (Former employee and covered dependents)	18 Months
Reduction of the employee's hours (Former employee and covered dependents)	18 Months
Death of a covered employee (Spouse and covered dependents)	36 Months
Divorce or legal separation from the covered employee (Spouse and covered dependents)	36 Months
Employee becomes entitled to Medicare (Part A, Part B or both) (Spouse and covered dependents)	36 Months
Dependent child covered under plan ceases to be an eligible dependent under the plan	36 Months
Person considered to have total disability, according to the Social Security Administration	29 Months

What events permit an extension of COBRA Continuation Coverage?

COBRA continuation coverage can be extended in one of two ways, which provides an extended period of time for certain Qualifying Events. Listed below are the two ways in which COBRA continuation coverage may be extended. Both require the covered employee to have incurred the first Qualifying Event of termination of the covered employee's employment or reduction of a covered employee's hours.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Department for Employee Insurance and your carrier in a timely fashion, you and your entire family may be entitled to receive up to an additional eleven (11) months of COBRA continuation coverage, for a total maximum of twenty-nine (29) months. The disability would have to have started before the sixtieth (60th) day of COBRA continuation coverage and must last at least until the end of the eighteenth (18th) month period of continuation coverage.

Second Qualifying Event extension of 18-month period of continuation coverage

If your family experiences another Qualifying Event while receiving eighteen (18) months of COBRA continuation coverage, the spouse and dependent children can get an extension of up to eighteen (18) months of COBRA continuation coverage, for a maximum of thirty-six (36) months. This extension may be available to the spouse and any dependent children receiving continuation coverage if the Department for Employee Insurance and the carrier are timely notified of the Qualifying Event. The chart below describes the events that qualify as a second Qualifying Event and the length of the extension permitted.

Second Qualifying Event	Length of Extension /Total Coverage Period
Former Employee Dies	18 Months / 36 Months Maximum
Entitlement of Medicare (Parts A or B or both)	18 Months / 36 Months
Divorce or Legal Separation	18 Months / 36 Months
Dependent Child ceases to be eligible under the Plan	18 Months / 36 Months

COBRA continuation coverage expressly requires that the first event be either termination of a covered employee's employment or reduction of a covered employee's hours.

If you have any questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to your insurance coordinator or to the Department for Employee Insurance. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA Web site at www.dol.gov/ebsa.

Keep your address current

In order to protect you family's rights, you should keep the Employer (insurance coordinator) informed of any address changes for you or your covered dependents. You should also keep a copy of any notices you send to your insurance coordinator for your records.

Plan Contact Information

The Plan Administrator is the Personnel Cabinet, Department for Employee Insurance, 200 Fair Oaks Lane, 5th Floor Suite 501, Frankfort, Kentucky 40601, 502-564-0358. If additional information

is needed, or you lose group health coverage, contact the above-referenced office for any questions or concerns regarding COBRA rights.

If you have any questions, please feel free to contact me at *Your Phone Number*.

Sincerely,

Your Name
Your Title
Agency Name

cc: file

COBRA CONTINUATION COVERAGE ELECTION NOTICE

Enter Date of Notice

Name of Beneficary
Address
City, State Zip

Dear *Identify the qualified beneficiary(ies), by name or status*:

This notice contains important information about your right to continue your health care coverage in the Public Employee Health Insurance Group (the Plan). Please read the information contained in this notice very carefully.

To elect COBRA continuation coverage, follow the instructions on the next page to complete the enclosed Election Form and submit it to us.

If you do not elect COBRA continuation coverage, your coverage under the Plan will end on *Enter Date* due to:

- ☐ End of employment
- ☐ Death of employee
- ☐ Entitlement to Medicare
- ☐ Reduction in hours of employment
- ☐ Divorce or legal separation
- ☐ Loss of dependent child status

Each person ("qualified beneficiary") in the category(ies) checked below is entitled to elect COBRA continuation coverage, which will continue group health care coverage under the Plan for up to (18 or 36) months:

- ☐ *Employee or former employee*
- ☐ *Spouse or former spouse*
- ☐ *Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage*
- ☐ *Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan*

If elected, COBRA continuation coverage will begin on *Enter Date* and can last until *Enter Date.*

COBRA continuation coverage will cost: *Enter amount each qualified beneficiary will be required to pay for each option per month of coverage and any other permitted coverage periods.* You do not have to send any payment with the Election Form. Important additional information about payment for COBRA continuation coverage is included in the pages following the Election Form.

If you have any questions about this notice or your rights to COBRA continuation coverage, you should contact the Personnel Cabinet, Department for Employee Insurance, 200 Fair Oaks Lane Suite 501, Frankfort, Kentucky 40601.

COBRA CONTINUATION COVERAGE ELECTION FORM

INSTRUCTIONS: To elect COBRA continuation coverage, complete this Election Form and return it to your insurance coordinator. Federal law requires that you must have 60 days after the date of this notice to elect COBRA continuation coverage under the Plan.

Send completed Election Form to: *Enter Name*
Address
City, State Zip

This Election Form must be completed and returned to your insurance coordinator. If mailed, it must be post-marked no later than *Enter Date*.

If you do not submit a completed Election Form by the due date shown above, you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed Election Form.

Read the Important Information About Your Rights, included on the pages after the Election Form.

I (We) elect COBRA continuation coverage in the Public Employee Health Insurance Group (the Plan) as indicated below:

Name	Date of Birth	Relationship to Employee	SSN (or other identifier)

a. _____

Coverage option elected: _____

b. _____

Coverage option elected: _____

c. _____

Coverage option elected: _____

_____ _____
Signature Date

_____ _____
Print Name Relationship to individual(s) listed above

_____

_____

_____ _____
Print Address Telephone number

IMPORTANT Information
About Your COBRA continuation coverage Rights

What is continuation coverage?

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage when there is a "Qualifying Event" that would result in a loss of coverage under an employer's plan. Depending on the type of Qualifying Event, "qualified beneficiaries" can include the employee (or retired employee) covered under the group health plan, the covered employee's spouse, and the dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment and special enrollment rights.

When is COBRA Continuation Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the insurance coordinator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the end of employment or a reduction of hours of employment, death of the employee or the employee becoming entitled to Medicare benefits (under part A, Part B or both), the employer must notify the insurance coordinator of the Qualifying Event.

You must Give Notice of Some Qualifying Events

For other Qualifying Events (divorce, legal separation of the employee and the spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Department for Employee Insurance within sixty (60) days after the Qualifying Event occurs. You must provide this notice to your insurance coordinator at place of employment.

Length of COBRA Continuation Coverage Period

Listed below is the maximum period COBRA continuation coverage is available.

Qualifying Events that entitle you to COBRA continuation coverage	Length of COBRA continuation coverage
Termination of employee's employment (except for gross misconduct) (Former employee and covered dependents)	18 Months
Reduction of the employee's hours (Former employee and covered dependents)	18 Months
Death of a covered employee (Spouse and covered dependents)	36 Months
Divorce or legal separation from the covered employee (Spouse and covered dependents)	36 Months
Employee becomes entitled to Medicare (Part A, Part B or both) (Spouse and covered dependents)	36 Months
Dependent child covered under plan ceases to be an eligible dependent under the plan	36 Months
Person considered to have total disability, according to the Social Security Administration	29 Months

What events permit an extension of COBRA Continuation Coverage?

If the covered employee has incurred a Qualifying Event of termination of employment or reduction of hours, then the employee could receive an extension of COBRA continuation coverage. To receive an extension of COBRA continuation coverage one of the following two situations must occur, either disability or second Qualifying Event. Descriptions of the two situations are in the next two sections.

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled, and you notify the Department for Employee Insurance and your Carrier in a timely fashion, you and your entire family may be entitled to receive up to an additional eleven (11) months of COBRA continuation coverage, for a total maximum of twenty-nine (29) months. The disability must have started before the sixtieth (60^{th}) day of COBRA continuation coverage and must last at least until the end of the eighteenth (18^{th}) month period of COBRA continuation coverage.

If you or anyone in your family covered under COBRA continuation coverage, is determined by the Social Security Administration to be disabled, you should contact the Carrier within sixty (60) days of the notification of disability.

Second Qualifying Event extension of 18-month period of COBRA continuation coverage

If your family experiences another Qualifying Event while receiving eighteen (18) months of COBRA continuation coverage, the spouse and dependent children may extend COBRA continuation coverage up to eighteen (18) months, for a maximum of thirty-six (36) months. This extension may be available to the spouse and any dependent children receiving COBRA continuation coverage if the Department for Employee Insurance and the Carrier receive timely notice of the Qualifying Event. The chart below describes the events that qualify as a second Qualifying Event and the length of the extension permitted.

Second Qualifying Event	Length of Extension /Total Coverage Period
Former Employee Dies	18 Months / 36 Months Maximum
Entitlement of Medicare (Parts A or B or Both)	18 Months / 36 Months
Divorce or Legal Separation	18 Months / 36 Months
Dependent Child ceases to be eligible under the Plan	18 Months / 36 Months

How can you elect COBRA continuation coverage?

To elect COBRA continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect COBRA continuation coverage. For example, the employee's spouse may elect COBRA continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect COBRA continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect COBRA continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, pre-existing condition may apply if you have more than a 63-day gap in health coverage, and election of continuation coverage may help to prevent the gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the Qualifying Event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of COBRA continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of COBRA continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including

continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

When and how must payment for COBRA continuation coverage be made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage no later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage within 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for verifying that the amount of your first payment is correct. You may contact your insurance coordinator to confirm the correct amount of your first payment.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the *Enter due date for periodic payments* for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan will not send periodic notices of payments due for these coverage periods.

Grace periods for periodic payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Your first payment for COBRA continuation coverage should be sent to:

Name of Insurance Coordinator
Address
City, State Zip

All future periodic payments should be sent directly to the appropriate carrier.

For more information

This notice does not fully describe COBRA continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description, from the Plan Administrator, or in your Public Employee Health Insurance Handbook.

If you have any questions concerning the information in this notice or your rights to coverage, you should contact your carrier.

For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA Web site at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site.)

Keep Your Plan Informed of Address Changes

In order to protect you and your family's rights, you should keep your insurance coordinator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the insurance coordinator.

COBRA HFSA CONTINUATION COVERAGE ELECTION NOTICE FOR HEALTH FLEXIBLE SPENDING ARRANGEMENTS

Date of Notice

Name of Beneficiary
Address
City, State Zip

Dear *Identify the qualified beneficiary(ies) by name or status*:

This notice contains important information about your right to continue your health care coverage in the Public Employee Health Flexible Spending Account (the HFSA Plan). Please read the information contained in this notice very carefully.

To elect COBRA HFSA continuation coverage, follow the instructions on the next page to complete the enclosed Election Form and submit it to your insurance coordinator.

If you do not elect COBRA HFSA continuation coverage, your coverage under the Plan will end on *Enter Date* due to:

- ☐ End of employment
- ☐ Death of employee
- ☐ Entitlement to Medicare
- ☐ Reduction in hours of employment
- ☐ Divorce or legal separation
- ☐ Loss of dependent child status

Each person ("qualified beneficiary") in the category(ies) checked below is entitled to elect COBRA HFSA continuation coverage, which will continue group health care coverage under the Plan for up to (18 or 36) months:

- ☐ *Employee or former employee*
- ☐ *Spouse or former spouse*
- ☐ *Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage*
- ☐ *Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan*

If elected, COBRA HFSA continuation coverage will begin on *Enter Date* and can last until *Enter Date.*

COBRA HFSA continuation coverage will cost: *Enter amount each qualified beneficiary will be required to pay for each option per month of coverage and any other permitted coverage periods.* You do not have to send any payment with the Election Form. Important additional information about payment for COBRA HFSA continuation coverage is included in the pages following the Election Form.

If you have any questions about this notice or your rights to COBRA HFSA continuation coverage, you should contact the Personnel Cabinet, Department for Employee Insurance, 200 Fair Oaks Lane Suite 501, Frankfort, Kentucky 40601 or by calling 1-888-581-8834.

COBRA HFSA CONTINUATION COVERAGE ELECTION FORM

INSTRUCTIONS: To elect COBRA HFSA continuation coverage, complete this Election Form and return it to your insurance coordinator. Federal law requires that you must have 60 days after the date of this notice to elect COBRA HFSA continuation coverage under the Plan.

Send completed Election Form to: *Enter name and address*
Address
City, State Zip

This Election Form must be completed and returned to your insurance coordinator. If mailed, it must be post-marked no later than *Enter Date*.

If you do not submit a completed Election Form by the due date shown above, you will lose your right to elect COBRA HFSA continuation coverage. If you reject COBRA HFSA continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date. However, if you change your mind after first rejecting COBRA HFSA continuation coverage, your COBRA HFSA continuation coverage will begin on the date you furnish the completed Election Form.

Read the Important Information About Your Rights, included on the pages after the Election Form.

I (We) elect COBRA HFSA continuation coverage in the Public Employee Health Insurance Group as indicated below:

Name	Date of Birth	Relationship to Employee	SSN (or other identifier)

a. _____

[*Add if appropriate:* Coverage option elected: _____]

b. _____

[*Add if appropriate:* Coverage option elected: _____]

c. _____

[*Add if appropriate:* Coverage option elected: _____]

_____ _____
Signature Date

_____ _____
Print Name Relationship to individual(s) listed above

_____

_____

_____ _____
Print Address Telephone number

IMPORTANT Information
About Your COBRA HFSA continuation coverage Rights

What is COBRA HFSA Continuation Coverage?

Federal law requires the Public Employee Health Insurance Plan ("the Plan") to give employees, and their families, notice of the opportunity to continue their health flexible spending arrangement (HFSA) when there is a "Qualifying Event" that would result in a loss of coverage under an employer's plan. Depending on the type of Qualifying Event, "qualified beneficiaries" can include the employee (or retired employee) covered under the group health plan, the covered employee's spouse, and the dependent children of the covered employee.

The purpose of COBRA HFSA continuation coverage is to permit qualified beneficiaries to continue coverage in order to avoid losing access to unused HFSA funds. In order to continue to receive the benefit of those unused funds, qualified beneficiaries must pay 102 percent of the cost of the contribution through the month that the qualified beneficiary plans to access the funds. The use-it-or-lose-it rule still applies to COBRA HFSA continuation coverage, meaning that at the end of the plan year you will lose all unused funds.

One legitimate question is why would anyone want to continue coverage if he/she must pay an extra 2 percent for the administration fee, while no longer benefiting from any tax breaks. The following example will illustrate why someone might want to continue coverage. Suppose that you experience a Qualifying Event at the end of October. As long as you incur an eligible medical expense before October, you may draw from your HFSA account to cover the medical expense. Now suppose that you had planned a surgery in December. In order to draw from the HFSA funds in your account in December, you must purchase COBRA HFSA continuation coverage for November and December. Then you may draw from all funds in your account minus the cost of the eligible medical expenses already reimbursed by the Plan during the plan year.

While enrolled in COBRA HFSA continuation coverage, the qualified beneficiary shall have all the rights possessed by active members participating in the Plan. This means that your coverage will be the same as the HFSA coverage you would have had, if the Qualifying Event never happened and you remained a participant in the Plan.

The remainder of this notice will further inform you of when COBRA HFSA continuation coverage is available, the length of the coverage, the cost of coverage, and the process of obtaining continuation coverage.

When is COBRA HFSA Continuation Coverage Available?

The Plan will offer COBRA HFSA continuation coverage to qualified beneficiaries only after the insurance coordinator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the end of employment or a reduction of hours of employment, death of the employee or the employee becoming entitled to Medicare benefits (under part A, Part B or both), the employer must notify their insurance coordinator of the Qualifying Event. For a full list of Qualifying Events, see the table on page 4.

You must Give Notice of Some Qualifying Events

For other Qualifying Events (divorce, legal separation of the employee and the spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Department for Employee Insurance within sixty (60) days after the Qualifying Event occurs. You must provide this notice to your Insurance Coordinator at place of employment.

Length of COBRA Continuation Coverage Period

Listed below is the maximum period COBRA HFSA continuation coverage is available. While you may exercise your right to participate for the maximum period, it might be in your best interest to cease COBRA HFSA continuation coverage at the end of the Plan Year. Since COBRA HFSA continuation coverage premiums are paid with taxed monies, a qualified beneficiary would be paying an additional 2 percent on claims incurred in the next Plan Year following the Qualifying Event. The only advantage to electing COBRA HFSA continuation coverage is if you are aware of a future claim that would occur after the Qualifying Event. For example, if you elected COBRA HFSA continuation coverage in October and you were aware of an impending claim in December, you would want to elect COBRA HFSA continuation coverage so that unused funds would be available to cover the cost of the claim.

Qualifying Events that entitle you to COBRA HFSA continuation coverage	Length of COBRA HFSA continuation coverage
Termination of employee's employment (except for gross misconduct) (Former employee and covered dependents)	18 Months
Reduction of the employee's hours (Former employee and covered dependents)	18 Months
Death of a covered employee (Spouse and covered dependents)	36 Months
Divorce or legal separation from the covered employee (Spouse and covered dependents)	36 Months
Employee becomes entitled to Medicare (Part A, Part B or both) (Spouse and covered dependents)	36 Months
Dependent child covered under plan ceases to be an eligible dependent under the plan	36 Months
Person considered to have total disability, according to the Social Security Administration	29 Months

How Can you Elect COBRA HFSA Continuation Coverage?

To elect COBRA HFSA continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect COBRA HFSA continuation coverage. For example, the employee's spouse may elect COBRA HFSA continuation coverage even if the employee does not. COBRA HFSA continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

How much Does COBRA HFSA Continuation Coverage Cost?

Generally, each qualified beneficiary may be required to pay the entire cost of COBRA HFSA continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent of the premium (including both employer and employee contributions) for a similarly situated plan participant or beneficiary who is not receiving continuation coverage.

For example, if you received the state contribution of $234 per month and you contributed nothing to your HFSA account, then you would pay $234 plus 2 percent, which is a total of $238.68. That means that you would have to pay the full $238.68 because you would no longer be eligible for the state contribution. If you contributed $100 per month to your HFSA account and your employer contributed nothing, then you would pay $102 per month for COBRA HFSA continuation coverage. In this case, you would only pay $2 more than you would have paid if you were still an HFSA plan participant.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65 percent of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

When and How Must Payment for COBRA HFSA Continuation Coverage be Made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage no later than 45 days after the date of your election. (This is the date the Election Notice is post-marked) If you do not make your first payment for continuation coverage within 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for verifying that the amount of your first payment is correct. You may contact your insurance coordinator to confirm the correct amount of your first payment.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the [*enter due day for each monthly payment*] for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan will not send periodic notices of payments due for these coverage periods.

Grace periods for periodic payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Send your first payment to your insurance coordinator with all future payments sent to:

Personnel Cabinet
Department for Employee Insurance
Attn. Mae Green/ Tara Moore
200 Fair Oaks Lane, Suite 502
Frankfort, Kentucky 40601

For More Information

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your Employee Health Insurance Handbook.

If you have any questions concerning the information in this notice or your rights to coverage, you should contact your insurance coordinator.

For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA Web site at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site.)

Keep Your Plan Informed of Address Changes

In order to protect you and your family's rights, you should keep your insurance coordinator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to your insurance coordinator.

Date of Notice

Name of Beneficiary
Address
City, State Zip

Your name and title

RE: Notice of Unavailability of Health Care Continuation Coverage

Dear *Name of Beneficiary*:

On *Insert Date*, we received your COBRA continuation coverage Qualifying Event notice, which stated that you are a qualified beneficiary entitled to COBRA Continuation Coverage because of *Insert Qualifying Event*.

Reviewer reviewed your notice and determined that continuation coverage was unavailable to you *and your dependents* because *Insert reasons and facts. In making this decision, Reviewer's Name also considered the following: Insert any additional steps of additional docuemnts reviewed.* Accordingly, you are not entitled to COBRA Continuation Coverage, and your coverage under the Public Employee Health Insurance Program will terminate on *Insert Termination Date*.

If you disagree with this determination, you can request its reconsideration by appealing the decision as follows:

1. Send a written appeal to the Personnel Cabinet, Department for Employee Insurance, 200 Fair Oaks Lane Suite 501, Frankfort, Kentucky 40601. This appeal must be received within thirty (30) days of this Notice.
2. Explain why you believe that you are entitled to COBRA Continuation Coverage, including all information you wish to be reviewed. Be sure to include your name, current address and the names of any covered dependents you wish to include in your appeal.

The Department for Employee Insurance will respond to your appeal within fourteen (14) days of its receipt.

If any of the individuals named above does not reside with you at the above address, we request that you immediately notify your insurance coordinator and the Carrier, so that we may provide a copy of this notice to those individuals. Your insurance coordinator's address and telephone number appear below.

If you have any questions regarding the information in this notice, you should contact the Department for Employee Insurance.

Sincerely,

Your name
Title
Agency Name

Insurance Coordinator's Name
Address
City, State zip
Phone Number

M E M O R A N D U M

TO: New Employees or Prospective Health Insurance Enrollees

FROM: (Name of State Agency, Board of Education, Local Health Department, KCTCS, etc.)

DATE:

NOTICE ABOUT SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself; your spouse and/or any of your eligible dependents because of other group health insurance coverage, you may be able to make a mid-year change in the Public Employee Health Insurance Program if you/they lose the other group health coverage. If other group health coverage is lost, you must request enrollment in the Public Employee Health Insurance Program no later than thirty (30) days of the loss.

In addition, if you acquire a new dependent as a result of marriage, birth, adoption, or the placement for adoption, you may be able to enroll yourself; spouse; and/or your dependents in the, Public Employee Health Insurance Program provided that you request enrollment within thirty (30) days of the date of the event. You will have sixty (60) days from the date of birth to add newborns. However, if you choose to add other eligible dependents at that time (birth of newborn), the change must be made no later than thirty (30) days.

NOTICE ABOUT WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Right's Act requires the Commonwealth to notify you, as a participant in the Public Employee Health Insurance Program, of your rights related to benefits provided through the program in connection with a mastectomy. You have rights to coverage provided in a manner determined in consultation with your attending physician for:

(1) all stages of reconstruction of the affected breast ;
(2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and
(3) prostheses and treatment of physical complications of the mastectomy, including lymphedema.

These benefits are subject to the plan's regular deductible, if any, and applicable co-payment or co-insurance amounts, depending upon the plan type and coverage option you have selected. For further details, please refer to your certificate of coverage.

Keep this notice for your records.

HEALTH INSURANCE CHECKLIST

NAME – LAST	FIRST	MIDDLE INITIAL	SOCIAL SECURITY NO.	
AGENCY NAME	**HIRE DATE MO DAY YR**	**WORK PHONE ( )**	**CO. OF RESIDENCE**	**COMPANY NUMBER**

Following is a list of your rights and responsibilities regarding the Public Employee Health Insurance Program. Read this form carefully and make sure you understand each item. You may direct your questions to the Insurance Coordinator or the Department for Employee Insurance.

As a new employee I understand:

___ I have thirty (30) days from my date of employment, or _____ (date specified by your employer) in which to enroll in one of the available health insurance plans.

___ I must submit all applications for health insurance (including if you waive coverage) and Flexible Spending Accounts to my agency's insurance coordinator.

___ I must choose a plan that is available in the county where I live, work or that is designated as a Contiguous county for purposes of health insurance only. If I live outside the Commonwealth of Kentucky, I must choose a plan that is available in the county where I work.

___ I will be subject to a one time twelve (12) month waiting period for pre-existing conditions unless I have had prior creditable coverage for at least twelve (12) months and there has been no more than a sixty-three (63) consecutive day break in coverage between the termination of that coverage and the effective date of my coverage with the Public Employee Health Insurance Program. Any prior period of coverage that is less than twelve (12) months can be applied against the pre-existing condition waiting period.

___ I must indicate my level of coverage on my application.

- SINGLE – Employee only
- PARENT PLUS – Employee and Dependent Child(ren)
- COUPLE – Employee and Spouse
- FAMILY – Employee, Spouse, and Dependent Child(ren)

___ I have confirmed the availability of my payment options with my insurance coordinator.

- MONTHLY – Health Insurance premium is deducted from the last paycheck of the month.
- TWICE MONTHLY – Health Insurance premium is deducted equally from both paychecks. **If I fail to choose a payment option, the premiums will be deducted twice monthly, if available.**

- CROSS-REFERENCE – The participating employer contribution for the Health Insurance Premium for both eligible spouses is applied toward the family coverage, with the remaining premium deducted equally from each spouse's paycheck.
  - NOTE: The husband and wife must be eligible for the employer contribution in the Public Employee Health Insurance Program.
  - Certain requirements must be met in order to cross-reference. See your *Health Insurance Handbook* for a listing of those requirements.

___ Every year there is a defined Open Enrollment Period for health insurance that provides me the opportunity to make ANY type of change in my health insurance coverage and Flexible Spending Account Program, if applicable. **NOTE: CHILDREN COVERED BY COURT ORDER OR ADMINISTRATIVE ORDER MAY NOT BE DROPPED FROM MY INSURANCE COVERAGE EXCEPT BY A SUBSEQUENT COURT ORDER OR ADMINISTRATIVE ORDER.**

___ Outside of the annual Open Enrollment Period I will only be allowed to make changes to my current plan and, in appropriate circumstances, change plans **within thirty (30) days of a Qualifying Event or up to sixty (60) days for newborns (see the Health Insurance Handbook for more information on adding newborns and when they will be effective)**. A list of Qualifying Events is available from your insurance coordinator or the Personnel Cabinet's Web site.

___ It is my responsibility to contact my agency's insurance coordinator no later than thirty (30) days of any event that may affect my coverage.

___ The State offers a Premium Conversion program that allows me to pay my portion of the health insurance premium with pre-tax dollars. I understand that I will automatically be enrolled in the program by virtue of enrolling in health insurance, unless I sign a cancellation form (refer to Appendix P).

___ My coverage will become **effective** on the first day of the second month following my employment or on a date stipulated by my employer.

___ If I experience a COBRA Qualifying Event, such as, but not limited to, termination of employment, I have the right to continue my health insurance at my own expense under COBRA.

___ If I decide that I DO NOT want the state-sponsored health insurance at this time, I can waive (decline) coverage by completing the appropriate sections of the application. If I waive coverage because I am covered under my spouse's plan, I will be allowed to enroll in a plan through the Public Employee Health Insurance Program if one of the following occurs:

1. my spouse's employer group health insurance terminates;
2. loss of eligibility;
3. the spouse's employer ceases contributing to the plan; or
4. if COBRA coverage is involved, the COBRA coverage expires.

Check with your spouse's health plan before waiving coverage. Some companies will not cover you if you are eligible for health benefits through your own employer.

___ I may have the opportunity to enroll in the Flexible Spending Account programs, if applicable, no later than thirty (30) days of my date of employment. I have obtained the appropriate Flexible Spending Account information and application from my insurance coordinator.

___ I may contribute my own money into either the Medical or Dependent Care Flexible Spending Account. Once I have directed money into the Medical Care FSA, changes are permitted for a HIPAA Special Enrollment Right or

a Change in Status (Qualifying Event) if the change is requested no later than thirty (30) days of the event giving rise to that right or change**.** Changes are allowed to the Dependent Care FSA with an approved Change in Status.

~~~~~~~~~~~~~~~~~~~~~~~~~~~~

___ Have you worked for any other agency participating in the Public Employee Health Insurance Program within the last sixty-three (63) days?
Yes ❒ No ❒
If yes, please give name of agency and date terminated or transferred.

_____ _____/_____/_____
Agency Date of Termination or Transfer

___ Are you retired from a state-sponsored retirement system?
Yes ❒ No ❒

If yes, please specify which system:

_____ Judicial Retirement Plan
_____ Legislators Retirement Plan
_____ KCTCS
_____ Kentucky Retirement System
_____ • County Employees Retirement System
_____ • Kentucky Employees Retirement System
_____ • State Police Retirement System
_____ Kentucky Teachers' Retirement System

I acknowledge that I have received copies of the:
_____*Health Insurance Handbook* and Supplement, if applicable
_____Health Insurance Application
_____Flexible Spending Account Handbook, if applicable
_____Flexible Spending Account Application, if applicable
_____Initial COBRA letter
_____Memorandum regarding Notice of Special Enrollment Rights and Women's Health and Cancer Right Act (refer to Appendix F)
_____Other _____

I certify that I have had my health insurance and Flexible Spending Account benefits explained and that I understand the benefits and my responsibilities.

Employee Signature **Date** **Agency Representative**

EMPLOYEE SHOULD KEEP THE ORIGINAL NOTICE FOR HIS/HER RECORDS.

INSURANCE COORDINATOR SHOULD KEEP A COPY IN THE EMPLOYEE'S
~~~~~~~~~~~~~~~~~~~~~~~~~~~~

SAMPLE

USE YOUR AGENCY LETTERHEAD

M E M O R A N D U M

TO: *(Employee on LWOP)*

FROM: *(Insurance Coordinator)*

DATE:

SUBJECT: Guidelines for Benefits While on Approved LWOP

As an employee on Leave Without Pay (LWOP), you are eligible to continue your health insurance, Commonwealth Choice contribution, and any miscellaneous insurance(s) that you are having payroll deducted at your own expense. You must contact *(Insurance Coordinator)* to make arrangements to continue your benefits coverage.

Health Insurance

To continue your group health insurance coverage you must pay the premiums to your agency or through COBRA. After you have been on LWOP for 30 or more working days, you will receive a COBRA Notification Letter.

A. If you are on LWOP and you have pay during the month the leave starts, you will be eligible for the employer contribution for health insurance for the following month. However, if the pay you receive is not sufficient to cover the employee's portion of the premium, you will need to submit a check for the amount due.

   If you are on leave without pay and you do not have pay during a month, you will not be eligible for the employer contribution for health insurance for the following month. In this case, you must pay the total premium amount (**employer and employee portion, if applicable**) to continue your health insurance coverage.

Any portion of a premium due by you must be submitted to the insurance coordinator by the **20th of the month**. The check must be payable to the appropriate **Insurance Carrier** and have your **social security number listed on the check**. The insurance coordinator will forward the payment to the appropriate Insurance Carrier.

NOTE: If you fail to submit appropriate premium payments due within the specified deadline, the Insurance Carrier may cancel the **ENTIRE POLICY**.

B. If you will be on LWOP for 30 or more working days, you must continue your coverage through COBRA. You will need to fill out the COBRA election form, new application and submit your COBRA premium(s), made payable to the insurance carrier, to your insurance coordinator, as instructed in the COBRA notification material. Your insurance coordinator will be responsible for mailing these COBRA materials to you after you have been on LWOP for 30 days or more.

Health Flexible Spending Account

To continue your participation in the Health Expense FSA you must submit a check to your insurance coordinator, in the amount of $_____ **made payable to *(FSA Third Party Administrator).*** If you do not continue this contribution while on LWOP, you will **not** be eligible to participate in the program for the remainder of the plan year once you return to work.

Miscellaneous Insurances (payroll deducted)

To continue your miscellaneous insurances that you are having payroll deducted, send payments directly to the insuring company. Our records indicate that you have the following additional insurance and/or deductions:

(List Payroll Deductions)

When you return to work after being on LWOP you must work more than half of the workdays in the month you return to be eligible to receive the employer contribution for health insurance for the following month. If you do not work more than half of the workdays in the month you return, the first day of the second month rule applies regarding your effective date of your health insurance.

When you return from LWOP your length of absence may affect your health insurance. If you do not elect to continue health insurance while on LWOP, and have more than a 63-day break in coverage, you will be subject to pre-existing conditions when your coverage resumes.

When you return to work after being on LWOP you will not be eligible to make any changes to the health insurance coverage in which you were enrolled prior to the LWOP unless one of the following has occurred:

- You experience a Qualifying Event and you apply for an appropriate change within thirty (30) days of that Qualifying Event except for the birth of a newborn baby, which would require you to apply within sixty (60) days.

- You return in a new plan year or after the open enrollment period and you apply for a coverage change no later than thirty (30) days after your return.

The insurance coordinator must provide the necessary applications upon return.

- The coverage in which you were enrolled in prior to the beginning of the LWOP is not available upon your return. You will have no more than thirty (30) days after your return to apply for an appropriate change. If you do not request the change, you will be subject to the auto-assignment guidelines.

The insurance coordinator must provide the necessary applications upon return.

Should you have any questions, you may contact me at _____.

SAMPLE

USE YOUR AGENCY LETTERHEAD

MEMORANDUM

TO: *(Employee on Family Leave)*

FROM: *(Insurance Coordinator)*

DATE:

SUBJECT: Guidelines for Benefits While on Approved Family Leave

This letter is to inform you of your health insurance responsibilities as an employee on family leave. As an employee on Family Leave, the state will continue to make the **employer** contributions for your health insurance and Commonwealth Choice (Flexible Spending Account), if applicable. It is your responsibility to make timely payments of any employee contribution amounts that had previously been deducted for health insurance or Commonwealth Choice.

Health Insurance

While on Family Leave, two conditions must be met in order to qualify for the employer contribution for health insurance. The first is you must maintain the level of coverage that was in effect before going on leave. Secondly, you must pay the employee contribution, if applicable. To continue your health insurance you must submit a check made payable to your insurance carrier, in the amount of $_____ (employee contribution).

Commonwealth Choice *(if applicable)*

If you are enrolled in Commonwealth Choice and contribute your own money (employee contribution), you may submit a check in the amount of $_____ made payable to ***[third party administrator]***. If you choose not to continue the employee contribution, the annual contribution amount will be adjusted accordingly. If you wish to resume your employee contribution when you return from Family Leave, you must complete a new enrollment form.

The payments for health insurance and Commonwealth Choice should be submitted to the following address by the 10th of each month. **Please include your Social Security number on each check.**

_____

_____

_____

Miscellaneous Insurances (payroll deducted)

All other insurances and deductions made from your paycheck will cease unless timely payments are made. You should contact the company directly. Our records indicate that you have the following additional insurance and/or deductions:

(List Payroll Deductions)

If you exhaust your Family Leave time before you are able to return to work, you will be sent a COBRA notification letter, which allows you to continue your health insurance totally at your own expense. Should you opt to not continue under COBRA, you will be restored to your previous level of coverage immediately upon your return to work.

If you have any questions, please feel free to contact me at _____.

Personnel Cabinet
Department for Employee Insurance

2005 Health Insurance Premiums (Total) by Region

		Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8
Commonwealth Essential	Single	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Couple	713.99	730.17	679.76	728.04	722.08	854.46	762.48	690.80
	Parent Plus	476.00	486.78	453.20	485.36	481.36	569.64	508.32	460.54
	Family	793.33	811.30	755.32	808.92	802.28	949.40	847.20	767.56
Commonwealth Enhanced	Single	403.28	412.53	394.80	403.96	400.64	496.28	447.52	405.44
	Couple	907.38	928.19	888.28	908.92	901.44	1,116.53	1,006.92	912.24
	Parent Plus	604.92	618.80	592.28	605.96	600.96	744.28	671.28	608.16
	Family	1,008.20	1,031.33	987.02	1,009.92	1,001.60	1,240.52	1,118.80	1,013.60
Commonwealth Premier	Single	412.47	421.95	407.48	422.16	418.64	512.16	474.88	430.24
	Couple	928.06	949.39	916.80	949.88	941.96	1,152.40	1,068.48	968.04
	Parent Plus	618.71	632.93	611.24	633.24	627.96	768.28	712.32	645.36
	Family	1,031.18	1,054.88	1,018.72	1,055.40	1,046.60	1,280.44	1,187.20	1,075.60

Personnel Cabinet
Department for Employee Insurance

2005 Health Insurance Employee Contribution
Monthly

Non-Smoker

	Single	Parent Plus	Couple	Family	Family Cross-Reference
Commonwealth Essential	Not offered	$55.00	$259.52	$320.14	$0
Commonwealth Enhanced	$0.00	$114.00	$357.72	$429.24	$9.72*
Commonwealth Premier	$18.20	$170.38	$398.66	$474.74	$33.08*

*Contribution is per employee

Smoker

	Single	Parent Plus	Couple	Family	Family Cross-Reference
Commonwealth Essential	Not offered	$85.00	$289.52	$350.14	$15.00*
Commonwealth Enhanced	$15.00	$144.00	$387.72	$459.24	$24.72*
Commonwealth Premier	$33.20	$200.38	$428.66	$504.74	$48.08*

*Contribution is per employee

Personnel Cabinet
Department for Employee Insurance

2005 Carriers by Region

Region 1	Ballard	Caldwell
	Calloway	Carlisle
Anthem Blue Cross Blue Shield	Crittenden	Fulton
	Graves	Hickman
	Livingston	Lyon
	McCracken	Marshall
Region 2	Christian	Daviess
	Hancock	Henderson
Anthem Blue Cross Blue Shield	Hopkins	McLean
	Muhlenburg	Ohio
	Todd	Trigg
	Union	Webster
Region 3	Breckinridge	Bullitt
	Carroll	Grayson
United Healthcare	Hardin	Henry
	Jefferson	Larue
	Marion	Meade
	Nelson	Oldham
	Shelby	Spencer
	Trimble	Washington
Region 4	Adair	Allen
	Barren	Butler
Bluegrass Family Health	Casey	Clinton
	Cumberland	Edmonson
	Green	Hart
	Logan	McCreary
	Metcalfe	Monroe
	Pulaski	Russell
	Simpson	Taylor
	Warren	Wayne
Region 5	Anderson	Bourbon
	Boyle	Clark
Bluegrass Family Health	Estill	Fayette
	Franklin	Garrard
	Harrison	Jackson
	Jessamine	Lincoln
	Madison	Mercer
	Montgomery	Nicholas
	Owen	Powell

	Rockcastle	Scott
	Woodford	
Region 6	Boone	Campbell
	Gallatin	Grant
United Healthcare	Kenton	Pendleton
Region 7	Bath	Boyd
	Bracken	Carter
CHA Health	Elliott	Fleming
	Greenup	Lawrence
	Lewis	Mason
	Menifee	Morgan
	Robertson	Rowan
Region 8	Bell	Breathitt
	Clay	Floyd
CHA Health	Harlan	Johnson
	Knott	Knox
	Laurel	Lee
	Leslie	Letcher
	Magoffin	Martin
	Owsley	Perry
	Pike	Whitley
	Wolfe	

Personnel Cabinet
Department for Employee Insurance

2005 Plan Codes

CARRIER	PLAN CODE
Anthem Blue Cross Blue Shield	463
Bluegrass Family Health	093
CHA Health	103
United Healthcare	323

Personnel Cabinet
Department for Employee Insurance

2005 COBRA Rates

	Commonwealth Essential	Commonwealth Enhanced	Commonwealth Premier
Region 1 – Anthem – Self-Insured			
Single	N/A	$411.35	$420.72
Couple	$728.27	$925.53	$946.62
Parent Plus	$485.52	$617.02	$631.08
Family	$809.20	$1,028.36	$1,051.80
Region 2 – Anthem – Self-Insured			
Single	N/A	$420.78	$430.39
Couple	$744.77	$946.75	$968.38
Parent Plus	$496.52	$631.18	$645.59
Family	$827.53	$1,051.96	$1,075.98
Region 3 – United Healthcare			
Single	N/A	$402.70	$415.63
Couple	$693.36	$906.05	$935.14
Parent Plus	$462.26	$604.13	$623.46
Family	$770.43	$1,006.76	$1,039.09
Region 4 – Bluegrass Family Health			
Single	N/A	$412.04	$430.60
Couple	$742.60	$927.10	$968.88
Parent Plus	$495.07	$618.08	$645.90
Family	$825.10	$1,030.12	$1,076.51
Region 5 – Bluegrass Family Health			
Single	N/A	$408.65	$427.01
Couple	$736.52	$919.47	$960.80
Parent Plus	$490.99	$612.98	$640.52
Family	$818.33	$1,021.63	$1,067.53
Region 6 – United Healthcare			
Single	N/A	$506.21	$522.40
Couple	$871.55	$1,138.86	$1,175.45
Parent Plus	$581.08	$759.17	$783.65
Family	$968.39	$1,265.33	$1,306.05
Region 7 – CHA Health			
Single	N/A	$456.47	$484.38
Couple	$777.73	$1,027.06	$1,089.85
Parent Plus	$518.49	$684.71	$726.57
Family	$864.14	$1,141.18	$1,210.94
Region 8 – CHA Health			
Single	N/A	$413.55	$438.84
Couple	$704.62	$930.48	$987.40
Parent Plus	$469.75	$620.32	$658.27
Family	$782.91	$1,033.87	$1,097.11

Personnel Cabinet
Department for Employee Insurance

2005 COBRA Calendar

QUALIFYING EVENT DATE	18 MONTHS	36 MONTHS
12/04	06/30/2006	12/31/2007
01/05	07/31/2006	01/31/2008
02/05	08/31/2006	02/28/2008
03/05	09/30/2006	03/31/2008
04/05	10/31/2006	04/30/2008
05/05	11/30/2006	05/31/2008
06/05	12/31/2006	06/30/2008
07/05	01/31/2007	07/31/2008
08/05	02/28/2007	08/31/2008
09/05	03/31/2007	09/30/2008
10/05	04/30/2007	10/31/2008
11/05	05/31/2007	11/30/2008
12/05	06/30/2007	12/31/2008

FLEXIBLE BENEFITS CANCELLATION FORM

Unless a Flexible Benefits Cancellation Form is signed, employees paying for insurance will AUTOMATICALLY be placed on Flexible Benefits (paying with pre-tax dollars. Serious consideration should be given to the Flexible Benefits plan, and if you do not want it, complete and sign this form.

Social Security Number	Name – Last	First	MI
- -			

Home Address – Number/Street	City	State	Zip Code

County	Home Telephone ( )	Employment Date
	Work Telephone ( )	- -

Name of State Agency	Company Number

I hereby elect to cancel my participation in the Flexible Benefits Plan. I understand that I will not have another opportunity to participate until a subsequent Open Enrollment Period. I also understand that signing this form does not cancel my health insurance coverage, only my opportunity to participate in the pre-tax method of payment.

Employee Signature

Date

Effective Date: